Vision Health CENTER, P.C.

Contact Information

Today's Date: _____

Patient Name: _____ Date of Birth: _____

Address: _____ City/State/ZIP: _____

Phone: (home) _____ (cell) _____ (work) _____

Email: _____ □ No Email Address

Occupation (or Grade): _____ Employer (or School): _____

May we leave messages for you with information about appointments, orders, or test results?

□ Yes, at this number: _____ □ No

Emergency Contact:

Name: _____ Relationship: _____ Phone #: _____

Other persons to whom we may release/discuss your medical information (minors/students list parent):

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Person responsible for payment of services not covered by insurance: □ Myself □ Parent □ _____

How did you hear about our office?

□ I am a Current Patient

□ Friend or Relative: _____ □ Health care provider: _____

□ Insurance provider □ Phone book □ Facebook □ Website: _____

□ Newspaper: _____ □ Radio: _____ □ Community event: _____

Signatures on File

- Copies of Vision Health Center, P.C.'s "Notice of Privacy Practices" are available at www.visionhealthcenter.net and both office locations. My signature acknowledges I have either received or accepted adequate access to a copy of the "Notice."
- I request that the payment of authorized insurance or Medicare benefits be made either to me, or on my behalf to Vision Health Center, P.C., for medical services furnished to me by Drs. Sloan or Smith. My signature authorizes release to my insurance company any medical information necessary to determine payment for related services.

Consent for use of eye drops for dependents/minors:

- As part of the comprehensive eye health examination, eye drops for the purpose of temporary anesthesia and/or pupillary dilation will be instilled. Blurred vision at near is a customary side effect. Dilation typically lasts for three to four hours; while some stronger dilating agents can last for more than 24 hours. My signature indicates consent for the use of these drops during examination today and on subsequent exams.

Patient (or Guardian) Signature: _____

Medical and Ocular History

Today's Date: _____

Patient name: _____ Date of Birth: _____

Medications: *(List name and dosage of all Rx and over-the-counter medications including vitamins and eye drops)*

_____

_____

_____

Primary Care Physician/Clinic: _____ **Pharmacy:** _____

Do you drive? □ Yes □ No **Are you currently Pregnant or Nursing** □ Yes □ No

Have <u>you</u> been treated for, or diagnosed with:

□ Cancer _____	□ Fatigue	□ Developmental disability			
□ Hearing loss	□ Sinusitis	□ Dry mouth			
□ Headache	□ Migraine	□ Seizures	□ MS	□ Tumor	□ Stroke
□ Autism	□ Depression	□ Anxiety		□ Bipolar	
□ High blood pressure	□ Cardiovascular disease	□ Congestive heart disease			
□ Asthma	□ Sleep apnea	□ COPD			
□ Acid reflux	□ Ulcer	□ Celiac		□ Crohn's	
□ Kidney disease	□ Herpes	□ Chlamydia		□ Gonorrhea	□ HIV
□ Osteoporosis	□ Fibromyalgia	□ Ankylosing spondylitis		□ Arthritis	□ Gout
□ Rosacea	□ Eczema	□ Psoriasis		□ Cold sores	□ Shingles
□ Type 1 diabetes	□ Type 2 diabetes	□ Thyroid dysfunction			
□ Elevated cholesterol	□ Anemia				
□ Rheumatoid arthritis	□ Lupus	□ Sjogren's		□ Sarcoidosis	
□ Cataract	□ Retinal detachment	□ Macular degeneration		□ Glaucoma	□ Lazy eye
□ Eye injury: _____		□ Eye surgery: _____			

Social History: Alcohol use: □ No □ Yes Amount: _____

Tobacco use: □ No □ Yes Status: □ never □ former □ current type: _____

Allergies: □ None □ Latex □ Seasonal □ Medications: _____ □ Other_____

Family Medical History:

□ Cancer	□ Father	□ Mother	□ Brother	□ Sister	□ Son	□ Daughter	□ _____
□ Diabetes	□ Father	□ Mother	□ Brother	□ Sister	□ Son	□ Daughter	□ _____
□ High Blood Pressure	□ Father	□ Mother	□ Brother	□ Sister	□ Son	□ Daughter	□ _____
□ Heart Disease	□ Father	□ Mother	□ Brother	□ Sister	□ Son	□ Daughter	□ _____
□ Cataracts	□ Father	□ Mother	□ Brother	□ Sister	□ Son	□ Daughter	□ _____
□ Macular Degeneration	□ Father	□ Mother	□ Brother	□ Sister	□ Son	□ Daughter	□ _____
□ Glaucoma	□ Father	□ Mother	□ Brother	□ Sister	□ Son	□ Daughter	□ _____
□ Lazy Eye	□ Father	□ Mother	□ Brother	□ Sister	□ Son	□ Daughter	□ _____
□ Retinal Detachment	□ Father	□ Mother	□ Brother	□ Sister	□ Son	□ Daughter	□ _____
□ _____	□ Father	□ Mother	□ Brother	□ Sister	□ Son	□ Daughter	□ _____

My Last Eye Exam was: □ Here, at Vision Health Center □ Never, this is my first □ Another Clinic: _____

I have been experiencing:

□ Blurred vision	□ Double vision	□ Tired eyes	□ Floating spots	□ Flashes of light	□ Eye infections
□ Dry eyes	□ Red eyes	□ Burning eyes	□ Itching eyes	□ Watery eyes	□ _____

I currently use:

□ Eye Drops □ Eye Vitamins □ Eyelid Cleansers □ Eye Masks for Sleep or Allergies □ Eye Makeup

I currently wear:

□ Glasses □ Computer Glasses □ Reading Glasses □ Sunglasses □ Safety glasses □ Sports glasses

□ Contact Lenses: Brand/type: _____ Cleaning Solution: _____ Replacement frequency_____

I am interested in:

□ Contacts □ Glasses □ Computer Glasses □ Reading Glasses □ Sunglasses □ Safety glasses □ Sports glasses □ LASIK