The Vision Clinic

			History or Problems
Guardian:			Allergy Melanoma
Name:			Asthma Respiratory Cancer Sinusitis
Address:			Cholesterol Thyroid
City, St:		Zip:	Diabetes 1 Other Diabetes 2
Phone(H):		(C):	Ear
Date of Birth:		Sex:	Heart disease
	imary Insurance		High B.P. Kidney Clear
	inary mourance	#:	Eye wear History (have you ever worn)
Ins.:			Amblyopia Glaucoma Other
Insured:		DOB:	Cataract Eye Injury
Relationship:			Crossed Eyes Macular Degeneration
Medical or S	econdary Insura	nce	Family History (parents, grandparents, siblings) Blindness Retina Detach
Ins.:		#:	Cancer Glaucoma
Insured:		DOB:	Crossed Eyes None
		202.	Color Blind Other
Relationship:			Macular Degen.
E-Mail:			Social History Occupation Computer Tennis Other
Notify me by:	Text Phone	☐ Email ☐ Mail	Reading Drug Abuse
Referred by (name of friend we can thank)			Student Alcohol Abuse Clean
Friend Insuranc Phone Book Other			Fishing No alcohol or drug abuse
			Ex-smoker Never smoked tobacco
			○ Heavy tobacco smoker○ Light tobacco smoker○ Light tobacco smoker
Medical Doctor(s):			Light tobacco smoker
Approx. Date of Last Eye Exam:			Current eye problem(s) (please check the "main" problem)
			Blur at Far Eye strain Medical eye check
Glasses R-			Blur at Near Flashes/Floaters Other Blur at Far & Near Loss of vision
L-			Itching Double vision
Contacts R-			Burning Sandy/Gritty
L-			Redness Spots or shadows
Drug Allergies	Current Med	icinas	Eye pain Diabetes eye check
Penicillin	Current Mea	icines	Right eye Left eye Both eyes
Sulfa			☐ Mild ☐ Moderate ☐ Severe
CODEINE			Started today 3-7 days 2-4 weeks 3-6 months
☐ VALIUM☐ Iodine			☐ 1-2 days ☐ 1-2 weeks ☐ 1-3 months ☐ Over 6 months
			Getting better Getting worse About the same
Race	Ethnicity	Language	Are you interested in contact lenses information?
			☐ Try Contacts ☐ Upgrade Contacts ☐ No interest in Contacts
Our office requires payment at the time of service unless we "accept assignment" on your insurance. You are responsible if your insurance doesn't pay. Should collection become necessary, I agree to pay all attorney's fees, court costs, filing fees, and all collection costs up to 33.33% of the amount owing which may be assessed by a collection agency. I/We further agree to pay \$2.00 every two weeks on balances over 60 days old. Contact lens fit and follow up care is billed separately from your eye exam. Your information is protected by our privacy policy and is available online for your "Health Vault" by asking for instructions. I have received a copy of Family Vision Clinic "Notice of Privacy Practices".			
Remind me	of my appointm	ent by: Text	SignatureDate
	2 F. L. 2 Mar.	<i>,</i> <u></u>	Relationship to Patient
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