The Vision Clinic

Guardian: _____ **Date:** _____

Name: _____ _____

Address: _____

City, St: _____ **Zip:** _____

Phone(H): _____ **(C):** _____

Date of Birth: _____ **Sex:** ____

Vision or Primary Insurance

Ins.: _____ **#:** _____

Insured: _____ **DOB:** _____

Relationship:

Medical or Secondary Insurance

Ins.: _____ **#:** _____

Insured: _____ **DOB:** _____

Relationship:

E-Mail: _____

Notify me by: ☐ Text ☐ Phone ☐ Email ☐ Mail

Referred by (name of friend we can thank)

☐ Friend ☐ Insuranc ☐ Phone Book ☐ Other...

Medical Doctor(s):

Approx. Date of Last Eye Exam:

Glasses R-
L-

Contacts R-
L-

Drug Allergies

- ☐ Penicillin
- ☐ Sulfa
- ☐ CODEINE
- ☐ VALIUM
- ☐ Iodine

Current Medicines

Race **Ethnicity** **Language**

History or Problems

- ☐ Allergy
- ☐ Asthma
- ☐ Cancer
- ☐ Cholesterol
- ☐ Diabetes 1
- ☐ Diabetes 2
- ☐ Ear
- ☐ Heart disease
- ☐ High B.P.
- ☐ Kidney
- ☐ Melanoma
- ☐ Respiratory
- ☐ Sinusitis
- ☐ Thyroid
- ☐ Other...

Clear

Eye wear History (have you ever worn...)

- ☐ Amblyopia
- ☐ Cataract
- ☐ Crossed Eyes
- ☐ Glaucoma
- ☐ Eye Injury
- ☐ Macular Degeneration
- ☐ Other...

Family History (parents, grandparents, siblings)

- ☐ Blindness
- ☐ Cancer
- ☐ Crossed Eyes
- ☐ Color Blind
- ☐ Macular Degen.
- ☐ Retina Detach
- ☐ Glaucoma
- ☐ None
- ☐ Other...

Social History

- ☐ Computer
- ☐ Reading
- ☐ Student
- ☐ Fishing
- ☐ Tennis
- ☐ Drug Abuse
- ☐ Alcohol Abuse
- ☐ No alcohol or drug abuse

Occupation

- ☐ Other...

Clear

- ◯ Ex-smoker
- ◯ Heavy tobacco smoker
- ◯ Light tobacco smoker
- ◯ Never smoked tobacco
- ◯ Tobacco Smoking Consumption unknown

Current eye problem(s) (please check the "main" problem)

- ☐ Blur at Far
- ☐ Blur at Near
- ☐ Blur at Far & Near
- ☐ Itching
- ☐ Burning
- ☐ Redness
- ☐ Eye pain
- ☐ Eye strain
- ☐ Flashes/Floaters
- ☐ Loss of vision
- ☐ Double vision
- ☐ Sandy/Gritty
- ☐ Spots or shadows
- ☐ Diabetes eye check
- ☐ Medical eye check
- ☐ Other...

☐ Right eye ☐ Left eye ☐ Both eyes

☐ Mild ☐ Moderate ☐ Severe

☐ Started today ☐ 3-7 days ☐ 2-4 weeks ☐ 3-6 months
☐ 1-2 days ☐ 1-2 weeks ☐ 1-3 months ☐ Over 6 months

☐ Getting better ☐ Getting worse ☐ About the same

Are you interested in contact lenses information?

Clear

☐ 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 appointment by: ☐ Text

Signature_____ Date_____

Relationship to Patient _____