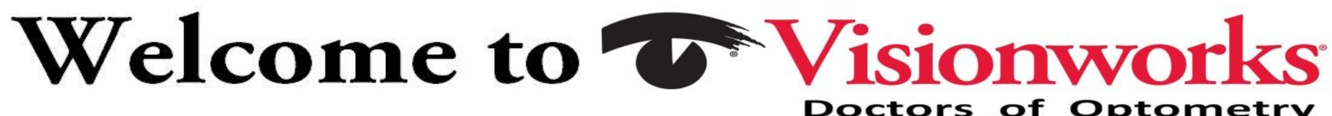

Name ____ DOB ______/______/_______ Age _______ Sex: M F
(PLEASE PRINT)
Race: Asian Black Hispanic White Other: _______________
Mailing Address _____________________________________
Ethnicity: Hispanic Latino Hawiian Other: _______________
City _____________________ State _______ Zip _____________
Home Phone ( ) - _______________
Occupation ____
Work Phone ( ) - _______________
Communication Preference: E-Mail Postal Phone Text
Mobile Phone ( ) - _______________
Preferred Language: English Spanish Other: ________________
E-Mail ____

Insurance Information

Please provide ALL insurance information (For Both MEDICAL and VISION Insurance Plans)
In order for our office to process your insurance claim, we may need to make a copy of your current insurance plan ID card(s).
Visionworks Doctors of Optometry participates with most VISION and MEDICAL Insurance Plans.

- VISION Insurance covers examinations specific to how your eyes see with glasses or contact lenses.
- MEDICAL Insurance covers medical health issues or diseases that affect the eyes.

If Medical health conditions of the eye are found during the examination, fees for services will be billed to your Medical Insurance.

Name of Primary Insurance		Name of Secondary Insurance	
Insurance ID Number		Insurance ID Number	
Policy Holder's Name		Policy Holder's Name	
Policy Holder's Date of Birth ______/______/_________	Sex: Male Female	Policy Holder's Date of Birth ______/______/_________	Sex: Male Female
Patient's Relationship to Policy Holder: Self Spouse Child Other: ____________		Patient's Relationship to Policy Holder: Self Spouse Child Other: ____________	

I understand it is my responsibility to pay co-pays at the time of service.
I understand that I am financially responsible for payment of any services provided, and which are not covered by my insurance, including but not limited to, deductible and co-insurance.
I request that payment of authorized insurance benefits, including Medicare, be made to Visionworks Doctors of Optometry for any services furnished to me by any provider employed or contracted by this office.

I authorize Visionworks Doctors of Optometry to release any medical information about me needed to process claims, determine benefits or the benefits payment for related services to my insurance companies, including insurance company agents or the Center for Medicare and Medicaid Services.
I also authorize Visionworks Doctors of Optometry to release any medical information about me to other health care providers who are involved in my treatment.

Visionworks Doctors of Optometry is concerned about the privacy of our patient's health care information. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your health care service will in no way be conditioned upon your signed acknowledgement. If you decline to provide a signed acknowledgement, we will continue to provide your treatment and will use and disclose your protected health information for treatment, payment, and health care operations when necessary.

I acknowledge that I have received the Visionworks Doctors of Optometry Notice of Privacy Practices. This authorization will remain in effect until revoked by me in writing.

Signature: ___________________________________ Date: _____/______/_______

(Patient or legal guardian if patient is a minor)

Relationship to patient: ____

MEDICAL HISTORY:

Name ____ (PLEASE PRINT)

Name & Address of Primary Doctor:	Name & Address of Pharmacy:
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

Are you Diabetic? ☐Y ☐N If YES please fill out this section:

How Long have you had Diabetes? ____________yrs. How do you control it? ☐Diet ☐Medication ☐Insulin

Average Blood Sugar Reading? ____________mg/dl Your Last Hemoglobin A1C Reading (if known)? _________%

☑ Please check ONLY if YOU or a family member have been diagnosed or treated for any of the following:

SELF	Medical Condition	Family Member	Family Relationship to me (Mother, Sibling, etc.)
☐	Asthma	☐	________________
☐	Arthritis	☐	________________
☐	Cancer Type:_______________	☐	________________
☐	Diabetes	☐	________________
☐	Emphysema	☐	________________
☐	Heart Disease	☐	________________
☐	Hepatitis	☐	________________
☐	High Blood Pressure	☐	________________
☐	High Cholesterol	☐	________________
☐	Kidney Disease	☐	________________
☐	Lupus	☐	________________
☐	Migraine Headaches	☐	________________
☐	Multiple Sclerosis (MS)	☐	________________
☐	Shingles	☐	________________
☐	Rosacea	☐	________________
☐	Sarcoidosis	☐	________________
☐	Stroke	☐	________________
☐	Thyroid Disease	☐	________________
☐	Tuberculosis	☐	________________
☐	Vertigo / Inner Ear Disorder	☐	________________
☐	Other Condition (Please Describe)	☐	________________

____

Are you Pregnant or Nursing? ☐Y ☐N

Do you use Tobacco Products? ☐Y ☐N

Do you Drink Alcohol? ☐Y ☐N

Do you use Illegal Drugs? ☐Y ☐N

Please List Medications:________________________________

____

____

____

Eye Health History:

SELF	Medical Eye Condition	Family Member	Family Relationship to me (Mother, Sibling, etc.)
☐	Blindness	☐	________________
☐	Cataracts	☐	________________
☐	Cornea Problems	☐	________________
☐	Crossed or Turned Eyes (Strabismus)	☐	________________
☐	Diabetic Retinopathy	☐	________________
☐	Dry Eye	☐	________________
☐	Glaucoma	☐	________________
☐	Iritis / Uveitis	☐	________________
☐	Keratoconus	☐	________________
☐	Lazy Eye (Amblyopia)	☐	________________
☐	Macular Degeneration	☐	________________
☐	Retinal Detachment	☐	________________
☐	Retinal Disease	☐	________________
☐	Other: ______________________	☐	________________

☑ Please CHECK ALL Symptoms that YOU have experienced within the past 90 days:

EYES

- ☐ Eye Strain / Discomfort
- ☐ Burning Eyes
- ☐ Redness
- ☐ Excess tearing / watering
- ☐ Foreign Body Sensation
- ☐ Mucous Discharge
- ☐ Infection of Eye or Eyelid
- ☐ Sandy or Gritty Sensation
- ☐ Eye Pain or Soreness
- ☐ Itchy Eyes
- ☐ Tired Eyes
- ☐ Dryness of the Eyes
- ☐ Light Sensitivity
- ☐ Loss of Vision (in any field of vision)
- ☐ Distorted Vision
- ☐ Blurry Vision
- ☐ Double Vision (two separate images)
- ☐ Floaters
- ☐ Flashes of Light
- ☐ Halos around Lights

OTHER SYMPTOMS

- ☐ Insomnia / Sleeplessness
- ☐ Dizziness / Vertigo
- ☐ Fever
- ☐ Allergies / Hay fever
- ☐ Sinus Congestion
- ☐ Runny Nose
- ☐ Dry Throat or Mouth
- ☐ Chronic Cough / Bronchitis
- ☐ Asthma / Emphysema
- ☐ Headaches
- ☐ Migraines
- ☐ Seizures
- ☐ High Blood Sugar
- ☐ Low Blood Sugar
- ☐ Heart / Chest Pain
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Depression
- ☐ Anxiety
- ☐ Miscellaneous Pain
- ☐ Intestinal Problems
- ☐ Acid Reflux
- ☐ Diarrhea
- ☐ Constipation
- ☐ Gas / Bloating
- ☐ Kidney / Bladder Problem
- ☐ Rheumatoid Arthritis
- ☐ Muscle Pain (neck/shoulder)
- ☐ Joint Pain (neck/shoulder)
- ☐ Anemia
- ☐ Bleeding / Bruising
- ☐ Weight Gain
- ☐ Weight Loss

Please List any Allergies:
____
____
____
____

☑ Please CHECK ALL that apply to your work, school, hobbies, or recreational activities:

- ☐ Reading
- ☐ Paperwork
- ☐ Driving
- ☐ Arts & Crafts
- ☐ Video Games
- ☐ Drawing
- ☐ Board work
- ☐ Gardening
- ☐ Sheet Music
- ☐ Playing Cards
- ☐ Computer Work: Hours per day: _________hrs.
- ☐ Detail Work
- ☐ Small Print
- ☐ Sports (ball sports, golf, running, cycling, boating, hunting, other: ____

When was your last Eye Exam? ___________________________________

Do you wear Glasses? ☐Y ☐N If YES, when? ☐ Full Time ☐ Part Time ☐ Distance ☐ Near / Reading

How old are your current Glasses? _____________ yrs.

Do you wear Contact Lenses? ☐Y ☐N If YES, How many hours / day? ________hrs. ☐ Full Time ☐ Part Time

Are you interested in wearing Contact Lenses? ☐Y ☐N

Do you have interest in Contact Lenses that can enhance or change your eye COLOR? ☐Y ☐N

Have you ever had any eye surgeries? ☐Y ☐N If YES, Which eye? ☐ Right ☐ Left ☐ Both

What type of surgery was performed? ☐ Cataract ☐ Glaucoma ☐ Eye Muscle ☐ Retina ☐ Other:_______________

Have you ever had any eye injuries? ☐Y ☐N If YES, Which eye? ☐ Right ☐ Left ☐ Both

Please Describe the type of injury: ____

Please List any other eye or vision complaints: ____