Welcome to Our Office

Patient Name_____
Last First Middle Initial

If Married, Name of Spouse_____If Child, Parent Name_____

Address _____ Apt./Suite _____

City_____ State _____ Zip _____

Home Phone (_____) _____ Cell Phone (_____)_____

Date of Birth _____/_____/_____ Age _____ Social Security #_____/_____/_____

Your Sex: ☐ Male ☐ Female E-Mail _____

Place of Employment / School_____ Business Phone (_____)_____

Occupation _____

List Activities / Hobbies you participate in that may require special vision care_____

Date of Last Eye Exam:_____ Were your pupils dilated(drops) at last exam? ☐ Yes ☐ No

Are you wearing contact lenses? ☐Yes ☐ No Are you interested in wearing contact lenses? ☐ Yes ☐ No

If you currently wear contacts, do your backup eyeglasses have your correct prescription? ☐ Yes ☐ No

If you currently wear eyeglasses, does your spare pair have your correct prescription? ☐ Yes ☐ No

If you currently wear eyeglasses, does your prescription sunglasses have UV protection? ☐ Yes ☐ No

Have you had, or are you considering, laser vision correction? ☐ Yes ☐ No

Reason for Today's Visit: _____

Any Special Eye or Vision Problems _____

How were you referred to our office? _____

GOVERNMENT REQUIRED INFORMATION (Check one in each section)

Primary Language: ☐ English ☐ Spanish ☐ French ☐ Other _____

Race: ☐ White ☐ Black or African American ☐ Asian
☐ Native Hawaiian or other Pacific Islander ☐ American Indian or Alaska Native
☐ Other Race ☐ Prefer not to answer

Ethnicity: ☐ Not Hispanic or Latino ☐ Hispanic or Latino
☐ Unknown ☐ Decline to Answer

INSURANCE INFORMATION

Primary Medical Insurance

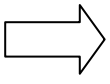
Name: _____ ID# _____ Group # _____

Secondary/Supplement Insurance

Name: _____ ID# _____ Group # _____

Vision Care Plan

Name: _____ ☐ VSP ☐ VCP/Humana



MEDICAL HISTORY

Medical Doctor ____ Last Visit ______/_____/_____

Reason for your visit to them: ____

Do you or your family have any of the following medical problems? Please check all that apply:

	Self	Family		Self	Family
Heart Problems	☐	☐	Diabetes	☐	☐
High Blood Pressure	☐	☐	High Cholesterol	☐	☐
Thyroid Problems	☐	☐	Cancer	☐	☐
Headaches	☐	☐	Lung Disease	☐	☐
Respiratory	☐	☐	Urinary	☐	☐
Gastrointestinal	☐	☐	Skin	☐	☐
Neurologic	☐	☐	Psychiatric	☐	☐
Sinus problems	☐	☐	Allergies	☐	☐
Arthritis	☐	☐	Asthma	☐	☐

Do You Use?

Cigarettes	☐ Y	☐ N
Alcohol	☐ Y	☐ N
Other Substances	☐ Y	☐ N

Have you ever been hospitalized or had any surgeries? Please explain if yes:

____

Medications? Please list all that you take:

____

Allergic to any Medications? Please List:

____

OCULAR HISTORY

Blurred Vision	☐
Computer Eye Strain	☐
Double Vision	☐
Tired when reading	☐
Spots / Floaters	☐
Dry Eyes	☐
Itchy Eyes	☐
Eye Surgery	☐

	Self	Family
Cataracts	☐	☐
Glaucoma	☐	☐
Macular Degeneration	☐	☐
Retinal Detachments	☐	☐
Blindness	☐	☐
Keratoconus	☐	☐

I have read a copy and have been informed about Glass Vision Associates NOTICE OF PRIVACY PRACTICES in accordance with HIPPA Privacy regulations.

☐ **Yes** **Please initial** ___________

I AUTHORIZE THIS OFFICE TO RELEASE ANY INFORMATION NEEDED TO EXPEDITE INSURANCE CLAIMS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES NOT COVERED BY MY INSURANCE. IF I FAIL TO PAY ANY OUTSTANDING BALANCES, I WILL ALSO INCUR ANY CHARGES ASSOCIATED WITH THE COLLECTION OF THESE FEES.

Signature: ____ Date :____________________