Patient Form

VISION SOURCE

General Information

Patient First, Last, MI, Preferred Name _____ Sex: **M / F**

Address: _____City:_____State:_____Zip:_____

Primary phone: _____ May we text you? **Y / N** Work: _____

Email: _____

Preferred contact method: ***phone - email - text***

Patient SSN: _____ Patient Date of Birth: _____

Occupation/Employer: _____

Marital status: ***married - single - divorced - legally separated - widowed***

Language: _____ Race: _____ Ethnicity: _____

Primary Care Physician: _____

Date of Last Eye Exam: _____ Does the patient wear glasses? **Y / N** Does the patient wear contacts? **Y / N**

Reason for today's visit: _____

Emergency contact person & phone #: _____

Whom may we thank for referring you to our office: _____

If under the age of 18

Guarantor Name: _____ Date of Birth: _____

Address: _____ City:_____ State:_____ Zip:_____

Phone #:_____ SSN: _____

Insurance Information

Primary Insurance: _____ Policy #:_____

Insurance Member Name: _____ Date of Birth: _____ SSN: _____

Secondary Insurance: _____ Policy #: _____

Insurance Member Name: _____ Date of Birth: _____ SSN: _____

Please fill out reverse side

Patient Health History

Has the patient experienced or been treated for any of the following?

Cataracts **Y / N** Crossed/Lazy Eye **Y / N** Glaucoma **Y / N** Lasik or RK **Y / N**

Macular Degeneration **Y / N** Retinal Detachment **Y / N**

Are you currently experiencing or have experienced any of the following? Circle all that apply.

Blurred Vision: *Near - Distance - Both* **Burning** **Discharge** **Dryness** **Excess Tearing/Watering**

Eye Infection **Eye Pain or Soreness** **Floaters or spots** **Halos** **Headaches** **Itching** **Light Flashes**

Light Sensitivity **Redness** **Sandy or Gritty Feeling**

Have you experienced or been treated for any of the following? Circle all that apply.

AIDS/HIV **Allergies** **Arthritis** **Asthma** **Cancer** **Diabetes** **Heart Disease**

High Blood Pressure **High Cholesterol** **Lupus** **Skin Conditions** **Stroke** **Thyroid Dysfunction**

Current Medications (prescription and non-prescription with dosage):

_____

_____

Medication drug allergies: _____

Height: _____ Weight: _____ Pregnant or Nursing? **Y / N**

Do you smoke? **Y / N** Have you ever smoked? **Y / N**

Family History

Has any family member been diagnosed with or been treated for any of the following? Circle all that apply & give relationship to you.

Crossed/Lazy Eye (relation):_____ Glaucoma (relation):_____

Macular Degeneration (relation):_____ Retinal Detachment (relation):_____

Has a family member experienced, or been treated for any of the following? Circle all that apply.

Allergies **Arthritis** **Asthma** **Cancer** **Diabetes** **Heart Disease** **High Blood Pressure**

High Cholesterol **Lupus** **Skin Conditions** **Stroke** **Thyroid Dysfunction**