*****PLEASE COMPLETE THIS FORM AND RETURN IT IN ENCLOSED ENVELOPE*****

WELCOME TO QUALITY VISION CARE

Patient Name_____ **Preferred Name**_____
Address_____**City**_____**State**_____**Zip**_____
Phone ( )_____ **Social Security Number**_____
Male_____ **Female**_____ **Date of Birth**_____ **Age**_____
Whom may we thank for referring you to our office? _____
Hobbies or Home Interests _____
To your knowledge, what is the main reason for your vision loss?_____

Personal Medical History

Yes	No	Explain
☐	☐	Diabetes_____
☐	☐	High Blood Pressure_____
☐	☐	Heart Problems_____
☐	☐	Thyroid Problems_____
☐	☐	Rheumatoid Arthritis_____
☐	☐	Multiple Sclerosis_____
☐	☐	Cancer_____
☐	☐	Migraine Headaches_____
☐	☐	Skin Condition_____
☐	☐	Breathing (lung) Condition_____
☐	☐	Allergies_____
☐	☐	Kidney disorder_____
☐	☐	Nerve disorder_____
☐	☐	Blood condition_____
☐	☐	Endocrine(gland) condition_____
☐	☐	Mental condition_____
☐	☐	Musculoskeletal condition_____
☐	☐	Genitourinary Condition_____
☐	☐	Do you use tobacco____alcohol____
☐	☐	Are you currently pregnant?

Personal Ocular History

Yes	No	Date
☐	☐	Cataracts _____
☐	☐	Iritis _____
☐	☐	Glaucoma _____
☐	☐	Macular degeneration ____
☐	☐	Retinal Detachment_____
☐	☐	Eye Surgery_____
☐	☐	Eye Injury_____

Date of Last Eye Exam_____
Doctor's Name_____

Family History

Yes	No	Relationship
☐	☐	Diabetes_____
☐	☐	High Blood Pressure_____
☐	☐	Heart Problems_____
☐	☐	Cancer_____
☐	☐	Cataracts_____
☐	☐	Glaucoma_____
☐	☐	Retinal Detachment_____
☐	☐	Macular Degeneration_____
☐	☐	Retinitis Pigmentosa_____
☐	☐	Eye Surgery_____

What medications are you currently taking? (Prescriptions, over the counter, eye drops)

_____

Allergies to any medications? _____ **Primary Care Physician** _____
Do you have Medical insurance? ____No ___Yes What type?_____
Do you have Vision Insurance? ____No ____Yes What type?_____
Do you have MEDICARE? __Yes __No Medicare Number _____
Do you have MEDICAID? __Yes __No Medicaid Number _____

******PLEASE PRESENT ALL INSURANCE CARDS FOR FILE COPIES.******

I understand that I am responsible for all financial obligations of services and products provided to me by Quality Vision Care. I authorize my insurance benefits be paid directly to Quality Vision Care.

Signature_____ **Date**_____

I have been given the opportunity to read the Notice of Privacy Practices of Quality Vision Care____ _____

Please initial and date-→ ____ _____