Vision Experts Optometry

PATIENT INFORMATION – PLEASE PRINT

Last Name	First Name	MI	☐ Male ☐ Female	☐ Single ☐ Married	Age	Date of Birth

Home Address	City	State	Zip	Referred By

Home Phone ( )	Cell Phone ( )	Work Phone ( )	Email Address

Employer Name	Occupation	Hobbies	Reason For Your Visit

Emergency Contact Person and Telephone #	**SIGNATURE** Date

INSURANCE INFORMATION

Insured's Name:	Name of Vision Insurance	Plan # or Name	Group #
SS #:			
Date of Birth:	Insured's ID #	Patient Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other	
Employer:			

PERSONAL HEALTH HISTORY

Please check (☑) conditions you have or have had in the past. Check here ☐ if none apply

☐ Diabetes
☐ High Blood Pressure
☐ High Cholesterol
☐ Thyroid Condition
☐ Cancer
☐ Asthma
☐ Lung Disease
☐ Heart Disease
☐ Currently Pregnant/Nursing

☐ Glaucoma
☐ Cataracts
☐ Retinal Disease
☐ Eye Injury
☐ Eye Surgery
☐ Crossed Eye(s)
☐ Headaches
☐ Other: ___________________

ALLERGIES you have to medication or substances

MEDICATIONS you are taking (including eye drops)

Do you use cigarettes/tobacco? ___________________ Alcohol? ___________________ Other substances? ___________________

FAMILY HEALTH HISTORY

Please check (☑) if your blood relatives had any of the following. Check here ☐ if none

☐ Diabetes	*Who?*	☐ Glaucoma	*Who?*	☐ Cataract	*Who?*
☐ High Blood Pressure	*Who?*	☐ Macular Degeneration	*Who?*	☐ Other: _________	*Who?*

NOTICE OF PRIVACY

Acknowledgement of Receipt of Privacy Notice

We are required by law to maintain the privacy of individuals, and provide them with this notice of our legal duties and privacy practices with respect to protected health information. **This office will only use and disclose necessary personal health information to another party to permit the office to perform its administrative duties, provide eye care services, process vision benefit claims, or mail exam reminders.**

By signing this, the patient acknowledges that he/she has reviewed & understood the Notice of Privacy Practices.

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Patient or Legal Guardian's Signature Date

DILATION CONSENT

Please read and check one of the following statements:

Dilated pupil examination helps the doctors to be able to more thoroughly examine the inside of the eye. It helps to detect hidden disease in the eye which may not cause symptoms, but which could be vision- or (in rare cases) life-threatening. Patients with a history of diabetes, high blood pressure, high cholesterol, autoimmune disease, and high prescriptions are especially encouraged to have an annual dilation. You may experience near blurred vision, and will be sensitive to light for about 4-6 hours.

☐ I want my pupils dilated.
☐ Permission to dilate minor child.
☐ Defer. Cannot be dilated today, I will reschedule my dilation within 2 weeks. ______________________________
☐ Decline. I have read and understand the above.

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Patient or Legal Guardian's Signature Date