CLEARVUE VISION CENTER

Patient Information

Name_____
Preferred Name_____
Street_____
Apt #_____City_____
State_____ Zip Code _____

Home Phone _____
Cell Phone_____
Work Phone_____
Email Address _____

Patient's SSN _____
Date of Birth _____ Sex M F

Employer_____
Occupation_____

Name of Family Physician_____
Location_____

Primary Insurance Subscriber Same as Patient ☐
Name_____
Address_____
_____
Employer_____
DOB_____
Relationship to patient_____

If the patient is under 18, please list parent/guardian:
Name:_____
Birthdate:_____
Relationship to patient:_____

Emergency Contact
Name/Relationship _____
Phone Number _____

Who may we thank for referring you to our office?

_____

What is the major purpose of this visit?

_____

At Clearvue Vision Center your vision and eye health are of utmost importance to us. Our commitment is to improve the quality of our patients' lives through better vision. Using the latest technology, our goal is to provide you with the highest quality eye care available, in a warm and inviting environment.

Lifestyle Questions

Check the box if your answer is yes

Do you work at a computer?
How many hours per day?_____
How do your eyes feel at the end of the day?
_____

( ) What hobbies do you have?
_____

( ) Do you spend time outdoors? How many Hrs/week___
( ) Do you have prescription sunwear?
( ) Do you want information on laser vision correction?

Are you currently experiencing, been diagnosed or treated for any of the following?

( ) Blurry Vision	( ) Burning
( ) Cataracts	( ) Corneal Abrasions
( ) Crossed eye/Eye turn	( ) Double Vision
( ) Eye Infections	( ) Eye Injury
( ) Flash of light	( ) Floaters/Spots
( ) Glaucoma	( ) Grittiness
( ) Headaches	( ) Iritis/Uveitis
( ) Itchiness	( ) Lazy Eye
( ) Macular Degeneration	( ) Dry Eyes
( ) Retinal Detachment	( ) Sunlight Sensitivity
( ) Tearing	( ) Trouble seeing at night

( ) Other eye disorders_____

Patient Eye History

Date of Last Eye Exam_____
By Whom?_____

Do you currently wear contact lenses? ( ) Yes ( ) No
What kind?_____
Solutions used_____
Is there a family medical history of any of the following:

	Relationship (Mother's or Father's side)
Blindness	( )_____
Cataracts	( )_____
Corneal Problems	( )_____
Diabetes	( )_____
Glaucoma	( )_____
Heart Disease	( )_____
Lazy Eye	( )_____
Macular Degeneration	( )_____

Patient Medical History

CURRENT MEDICATIONS (Rx or Over the Counter)
(List name of medications including eye drops, vitamins, & birth control pills)

_____

_____

Do you use cigarettes/tobacco, alcohol, or other substances? ( ) Yes ( ) No Have you had any surgeries? ( ) Yes ( ) No

Allergies to medications? ( ) Yes ( ) No
If so, what
medications?_____
_____

Have you ever been diagnosed or treated for the following health problems?

	Yes	No		Yes	No
Allergies	( )	( )	Arthritis	( )	( )
Blood/Lymph	( )	( )	Bronchitis	( )	( )
Cancer	( )	( )	Cholesterol	( )	( )
Diabetes	( )	( )	Digestive	( )	( )
Ears/Nose/Throat	( )	( )	Endocrine	( )	( )
Eczema/Rashes	( )	( )	Fatigue	( )	( )
Fevers	( )	( )	Genitourinary	( )	( )
High Blood Pressure	( )	( )	Integumentary (Skin)	( )	( )
Kidney	( )	( )	Muscle/Bone	( )	( )
Neurological	( )	( )	Psychological	( )	( )
Respiratory	( )	( )	Sinus	( )	( )
Throat Infections	( )	( )	Thyroid	( )	( )
Unusual weight losses/gains	( )	( )			

Please be advised if you are using insurance coverage for today's visit, this is a contract between you and your insurance company, not Clearvue Vision Center. All copays are due at time of appointment. All benefits quoted are not a guarantee of payment by your insurance company and final determination can only be made when the claim is processed. If your insurance company has not reimbursed our office in full within 90 days, you will be responsible to pay for those office fees.

Initial _____

Please give 24 hours notice if you cannot make your scheduled appointment. If you fail to do so, there will be a $40.00 No Show fee.

****Co-pay is due at time of service****

Eyewear returns are subject to a $40.00 restocking fee. Returned checks are subject to a $25.00 fee.

HIPAA Notice of Privacy Practices acknowledgement
A copy of our HIPAA Notice is available to you at any time upon request.

I acknowledge that Clearvue Vision Center has given me a copy of the Privacy Notice.

_____ _____
Patient or Parent Signature Date