

**General Health**

- Excellent  Good  Fair  Poor

**Have you experienced any of the following recently?**

- Weight Change  Fever  Cancer  Cancer in remission

**Are you currently under treatment or a doctor's care for any of the following?**

**No Medical Conditions**

- Heart
- Allergies, Sinus Asthma
- Sleep Apnea
- Stomach/Digestion
- Urinary
- Arthritis
- Osteoporosis
- Fibromyalgia
- Anxiety
- Depression
- Skin Conditions
- Cancer, Type \_\_\_\_\_
- Migraines
- Parkinson's
- Memory Problems
- High Cholesterol
- Diabetes \_\_\_\_\_ Years
- Thyroid
- Anemia
- Hypertension
- Other \_\_\_\_\_
- Other \_\_\_\_\_

**Vision**

**Do you currently experience any of the following?**

- Blurred Vision
- Headaches
- Eye Itching
- Burning of Eyes
- Eye Redness
- Gritty Feeling
- Mattering or Stickiness
- Eye Dryness
- Ache or Pain in or around eyes
- Seeing Double
- Light Sensitivity
- Floaters or Spots
- Light Flashes in outer vision
- Other \_\_\_\_\_
- Other \_\_\_\_\_

**What are the main reasons for your appointment today?** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Previous eye injuries?**  NO  YES

**Previous head injuries or falls?**  NO  YES

**Are you a smoker?**  
 **Current**  **Former**  **Never**

**Do you drink alcohol?**  NO  YES

**FINANCIAL POLICIES:**

Professional service fees and co-pays are due on the day of service. Eyewear and contact lenses charges are to be paid in full at the time of ordering. Prompt payments for amounts unpaid for by insurances are expected. The Parent or Guardian who accompanies minors will be responsible for payment of charges.

**Authorization for Billing:** I authorize Young Vision Care to release any information including the diagnosis and the records of any treatment or examination rendered to myself or my dependent during the period of such eyecare to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to Young Vision Care benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. *Insurance Disclaimer: Any and all quotes of insurance benefits to be paid are not a guarantee of payment.*

**Notice of Privacy Practices:**

I acknowledge that a copy of the Notice of Privacy Practices has been made available to me and I can request a copy at any time.

Date: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Printed Name: \_\_\_\_\_

Or \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_