

# PATIENT INFORMATION

DATE \_\_\_\_\_

LAST NAME FIRST M.I.

ADDRESS

CITY STATE ZIP CODE

PRIMARY PHONE # ALTERNATE PHONE #  Cell  Work

EMAIL OCCUPATION

Preferred method of contact  Primary #  Alternate#  E-mail  Mail  Text Message

FAMILY DOCTOR CITY ADDITIONAL CONTACT PERSON PHONE #

### Health History

Check all that apply to you or that you have a history of:

- Alcohol Use
  - Allergies/ Hay Fever
  - Anxiety/ Depression
  - Arthritis
  - Asthma
  - Cancer
  - Skin Conditions
  - Diabetes
  - Gastrointestinal
  - Heart Problems
  - High Blood Pressure
  - High Cholesterol
  - Lung/ Breathing Problems
  - Migraines
  - Parkinson's
  - Pregnant/ nursing
  - Recent Fever
  - Recent Weight Change
  - Seizures
  - Sinus Congestion
  - Sleep Conditions
  - Stroke
  - Thyroid problems
  - Tobacco Use
- (All not checked are normal)

Other Health Concerns and Details:

### Your Eye History

Please check any that apply to you:

- Cataracts
- Eye Injuries
- Head Injury
- Eye Turn
- Glaucoma
- Lazy Eye
- Macular degeneration
- Retinal Detachment
- LASIK Procedure

### MEDICINES & SUPPLEMENTS:

(If you have a list, we will copy)

DATE OF BIRTH (MONTH/DAY/YEAR) AGE

Male  Female

If student grade level: \_\_\_\_\_

### Do you currently wear:

Contact Lenses  Glasses

### Are you interested in:

LASIK  New Glasses

Contacts\*

\*(Additional professional fees will apply for these services)

### Please list your hobbies or interests

Daily hours on computer: \_\_\_\_\_

### Family History

Do you have a family history of: (mother, father, grandparents, sibling)

Check all that apply: Who?

- Cataracts \_\_\_\_\_
- Diabetes \_\_\_\_\_
- Glaucoma \_\_\_\_\_
- Heart Problems \_\_\_\_\_
- Macular Degeneration \_\_\_\_\_
- Retinal Detachment \_\_\_\_\_
- Stroke \_\_\_\_\_

### ALLERGIES TO MEDICINES:

## FINANCIAL INFORMATION- Please provide insurance card(s) for copy

Primary Insured  Self  Other \_\_\_\_\_

NAME OF OTHER

DATE OF BIRTH

**\*\*SSN OF POLICY HOLDER\*\***

Vision Insurance  VSP  Avesis  Medicaid  Other \_\_\_\_\_  No Vision Insurance

Medical Insurance  BCBS  UHC  Medicare  Tricare  Coventry  Hawk-I  Other \_\_\_\_\_  
 No Medical Insurance

EXAM COPY \_\_\_\_\_

### 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 are responsible for payments 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.

Signature of Patient or Responsible Party \_\_\_\_\_ Date \_\_\_\_\_