VISION REHABILITATION ASSOCIATES, P.C.
DOCTORS OF OPTOMETRY

Deana LaBrosse, O.D.
Michael Zost, O.D., FCOVD

Date Completed: _____

Welcome back to Vision Rehabilitation Associates, P.C. Please take a few minutes to update your information as completely as you can.

PATIENT INFORMATION

Name _____ Age _____ Birth date _____ Email Address _____

Address _____

Phone [H] _____ Phone [W] _____ Phone [C] _____ Preferred Contact Method: Phone • Mail • Email

Primary Insurance Company _____ Subscriber's Name _____

Secondary Insurance Company or Vision Plan _____ Subscriber's Name _____

NOTICE OF PRIVACY PRACTICES

I acknowledge that I been offered a copy of Vision Rehabilitation Associates' Notice of Privacy Practices. Signature: _____ Date: _____

ASSIGNMENT OF INSURANCE BENEFITS / PAYMENT GUARANTEE

I hereby authorize payment to be made directly to Vision Rehabilitation Associates, P.C. for vision plan or insurance benefits payable to me for services or materials rendered that I have received from Vision Rehabilitation Associates, P.C.. I understand that I am financially responsible to Vision Rehabilitation Associates, P.C. for any non-covered services or materials, as defined by my insurer, which are not paid by my primary or secondary insurer. I also understand that if my account balance becomes overdue and the overdue account is referred to a collection agency, a collection fee will be added to the amount due and that I am financially responsible for the added costs also.

Signature: _____ Date: _____

Vision Rehabilitation Associates is not a provider for the below insurance company:

_____

REASON FOR YOUR VISIT

What is the nature of your appointment today?

_____

Do you wear contact lenses? ❒ No ❒ Yes Brand if known _____

Hours Worn /Day _____ Replacement Schedule _____

Pairs Left _____ Solutions used _____

How old is the pair you have in your eyes today? _____

HEALTH HISTORY

Date of your last physical _____

Primary Care Doctor _____

Address _____ Phone _____

Please place a "√" in any ❒ to indicate if you or any blood relative has had any of the following problems (including parents, grandparents, uncle, aunts, or siblings).

	Yourself	Family Members
Anxiety	❒	❒
Asthma	❒	❒
Cancer	❒	❒
Cataracts	❒	❒
Depression	❒	❒
Diabetes	❒	❒
Epilepsy	❒	❒
Glaucoma	❒	❒
Headaches	❒	❒
Head Injury	❒	❒
Heart Condition	❒	❒
Herpes / Shingles	❒	❒
High Blood Pressure	❒	❒
High Cholesterol	❒	❒
HIV / AIDS	❒	❒
Macular Degeneration	❒	❒
Multiple Sclerosis	❒	❒
Myasthenia Gravis	❒	❒
Sickle Cell or Trait	❒	❒
Skin Disorder	❒	❒
Stroke	❒	❒
Thyroid Condition	❒	❒

Other _____

Are you pregnant or nursing? [Females Only] ❒ Yes ❒ No

Do you use tobacco? ❒ Yes ❒ No Do you use alcohol? ❒ Yes ❒ No

ALLERGIES / SENSITIVITIES

Please indicate if you have any allergies or sensitivities in the categories below.

Drugs (Please List)

_____

Foods (Please List)

_____

Seasonal / Environmental (Please include which season bothers you most)

_____

MEDICATIONS / VITAMINS / SUPPLEMENTS

Please indicate if you use any prescribed or over-the-counter medications.

Medications (Please List)

_____

_____

Vitamins / Supplements (Please list and indicate how often used)

_____

Eye Drops (Please list and indicate how often used)

_____