

We are pleased to welcome you to our practice. The following information will aid us in providing the most complete care possible. Please take a few minutes to fill out this form as completely as you can. If you have questions, we will be glad to assist you.

PATIENT INFORMATION **REASON FOR TODAY'S VISIT**

Name _____
 Address _____
 City _____ State _____ Zip _____
 Phone (Home) _____
 Phone (Work) _____
 Phone (Cell) _____
 Email _____
 Preferred Contact Method: Mail Phone Email
 Sex M F Age _____ Birth date _____
 SS# _____

Occupation _____ Employer _____
 If a Student, School Name _____ Grade Enrolled in _____

To best monitor for ethnic related health and vision conditions, please check if any apply:

Black or African American
 American Indian or Alaska Native
 Asian, Asian American, or Pacific Islander
 Hispanic
 White

Do you use tobacco? Yes No Do you use alcohol? Yes No
 Are you pregnant or nursing? [Females Only] Yes No

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 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 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 following insurance company: _____

Date of last eye exam _____ Eye Doctor's Name _____
 Were you referred by a doctor? Y N Doctor's name: _____
 Annual Check-up, Not Having Any Problems
 Need Stronger Prescription for Distance Tasks
 Need Bifocals, Reading Spectacles, or Glasses for Computer Use
 Replace Lost or Broken Spectacles
 Need a Back-up Pair of Spectacles or Sunglasses
 Need More Contact Lenses
 Would Like to Try Contact Lenses
 Trouble Using Eyes Comfortably
 Other _____

To get a better sense of how you use your eyes, are there any hobbies, sports, or other recreational activities you participate in on a regular basis?

Do you currently wear glasses? Yes No
 All the time Occasionally
 For Distance tasks For Near Tasks For Computer Use

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

Pairs Left _____ Replacement Schedule _____

Hours Worn /Day _____ Solutions used _____

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

EYE / VISION CONCERNS **HEALTH HISTORY**

Place a "v" in any to indicate if you are experiencing any of the following.

- Blurred Vision – Distance
- Blurred Vision – Near
- Burning Eyes
- Crossed or Wandering Eye
- Crusty Eyelids
- Discharge from Eyes
- Dizzy Spells
- Double Vision
- Dry Eyes
- Eye Infection or Eye Injury
- Eye Strain, Fatigue, or Tiredness
- Fluctuating Vision
- Headaches
- Itching Eyes
- Light Sensitivity
- Poor Night Vision
- Red Eyes
- Seeing Flashes or Floaters, Halos or Spots
- Styes
- Temporary Loss of Vision
- Twitching Eyelid

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

- | | | |
|------------------------|--------------------------|--------------------------|
| Cataracts | <input type="checkbox"/> | <input type="checkbox"/> |
| Eye Surgery | <input type="checkbox"/> | <input type="checkbox"/> |
| Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> |
| Lazy Eye or Turned Eye | <input type="checkbox"/> | <input type="checkbox"/> |
| Macular Degeneration | <input type="checkbox"/> | <input type="checkbox"/> |
| Retinal Detachment | <input type="checkbox"/> | <input type="checkbox"/> |
| Vision Training | <input type="checkbox"/> | <input type="checkbox"/> |

Place a "v" in any to indicate if you have any sensitivities or allergies in the categories below.

- Drugs (Please List) _____
- Foods (Please List) _____
- Environmental / Seasonal (Please include which season bothers you most) _____

Date of your last physical _____
 Primary Care Physician's name _____
 Phone Number _____

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

	Yourself	Family Members
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Blindness	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Head Injury	<input type="checkbox"/>	<input type="checkbox"/>
Heart Condition	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Migraine Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
Sickle Cell or Trait	<input type="checkbox"/>	<input type="checkbox"/>
Shingles	<input type="checkbox"/>	<input type="checkbox"/>
Skin Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Condition	<input type="checkbox"/>	<input type="checkbox"/>
Other	_____	_____

MEDICATIONS / VITAMINS / SUPPLEMENTS

Place a "v" in any to indicate if you use any prescribed or over-the-counter substances in the categories below.

- Eye Drops (Please List) _____
- Medications (Please List) _____
- Vitamins / Supplements (Please List) _____