Patient Information
Thank you for choosing VisionOne!

Last Name _____ First Name _____ M.I. _____

Address _____ City _____ Zip _____

Telephone _____ _____ _____ SS# _____
("x" preferred phone#) (□home) (□work) (□cell)

Email address _____ Birth Date ____/____/____ Marital Status: _____

May the office and doctor contact you by email ? _____ by texting? _____

Employer (or school) _____ Occupation (or grade) _____

Emergency Contact and telephone # _____

Please circle any that influenced you to choose VisionOne: referred by friend, relative or doctor _____
insurance list website walk-in yellow pages advertisement other _____

Other family members that are patients here _____

Vision Insurance _____

If not self: Policy holder's name _____ Date of birth _____

Last 4 digits of policy holder's SSN: _____

Medical Insurance _____ ID# _____ Group# _____
Refraction (determination of eyeglass prescription) is not covered by medical insurance.

If not self: Policy holder's name _____ Date of birth _____

I acknowledge that I have received a copy of the Notice of Privacy Practices. Initial _____ Date _____

I hereby authorize VisionOne to furnish information to insurance carriers or to other doctors involved in my care concerning my illness and treatments. I hereby assign to the physician all payments for medical/optical services rendered to me or my dependents. I understand that I am responsible for any amount not covered by my insurance.

CONTACT LENS PORTION OF EXAM MAY NOT BE COVERED BY INSURANCE. Contact lens evaluation fees include any followup visits required for 60 days. Contact lens prescriptions require that the contact lens fit has been assessed and deemed successful, and expire in 12 months.

Method of payment today: Cash check MC/Visa/Discover

Responsible party/Guarantor, if different than patient:

Name _____ Relationship to patient _____

SIGNATURE _____ DATE _____ ***Thank You!***

VisionOne Patient Medical History and Review

Name: _____ **Date:** _____

Date of last eye exam (if not here) _____ **Doctor's name or location** _____

Main reason for today's visit _____

Other eye questions or needs to be addressed _____

Do you currently wear glasses	**Y/N**	**Do you currently wear contacts**	**Y/N**	**Brand, Rx:** _____	
Do you wear sunglasses or UV protection	**Y/N**	**Are you interested in contacts**	**Y/N**	**Do you use eyedrops**	**Y/N**
Are you interested in refractive surgery	**Y/N**	**Do you see flashes or floaters**	**Y/N**	**Do you have dry eye**	**Y/N**
Do you see double, or have a turned eye	**Y/N**	**Do you have ambylopia or lazy eye**	**Y/N**	**Do you need protective eyewear**	**Y/N**

List any eye injuries or eye surgeries, current or past eye disease: _____

_____

Primary Care Physician name and location _____ **Pharmacy name and location** _____

Date last seen by primary care doctor: _____

Medical History and Review of Systems

Your eyes are a part of your body. Health problems that you may have, or medications that you take, could have an important interrelationship with your eye exam. Thank you for answering the following questions:

Have you been diagnosed with, or have symptoms of problems in the following areas? For each, please circle YES/NO, **If yes, please explain**

Constitution: YES/NO _____
(Chronic fever, fatigue, sudden weight change, insomnia, other)

Ear/Nose/Throat: YES/NO _____
(hearing loss, ringing in ears, sinus problems, sore throat, other)

Cardiovascular: YES/NO _____
(High blood pressure, heart disease, chest pain, irregular heart beat, other)

Respiratory: YES/NO _____
(COPD, asthma, shortness of breath, wheezing, TB exposure, other)

Gastrointestinal: YES/NO _____
(GERD, ulcers, constipation, diarrhea, abdominal pain, change in appetite, other)

Genitourinary: YES/NO _____
(Kidney disease, Urinary tract infection, STD's, urinary or reproductive problems, other)

Musculoskeletal: YES/NO _____
(Arthritis, Gout, back pain, muscle pain, joint pain or swelling, muscle cramps, other)

Integumentary, i.e. Skin, Hair: YES/NO _____
(Cancer, eczema, rash, dryness, abnormal lesions, hair loss, other)

Neurological: YES/NO _____
(Headaches, memory loss, tremors, weakness, numbness or tingling, seizures, other)

Psychological: YES/NO _____
(Depression, anxiety, ADHD, mental illness, irritability, lethargy, other)

Endocrine: YES/NO _____
(Diabetes, thyroid disease, liver disease, heat or cold intolerance, increased thirst, other)

Hematological/lymphatic: YES/NO _____
(Anemia, blood disorder, enlarged or tender lymph nodes, bleeding or bruising, other)

Allergic/Immunological: YES/NO _____
(Medication, Seasonal allergies, other allergies, hives, autoimmune disorder, immunodeficiency, other)

Have you had cancer: YES/NO Type:_____

Are you pregnant or nursing? YES/NO _____

Current Medications, prescription or over the counter: include dosage if possible

_____
_____
_____
_____
_____
_____
_____
_____

Previous Surgeries (please list and date)

_____
_____
_____
_____

Your Height _____ **Weight** _____

Immediate Family Medical History

Do you have a **M**other, **F**ather, **S**ister or **B**rother with

Glaucoma	M F S B
Macular Degeneration	M F S B
Retinal Detachment	M F S B
Blindness	M F S B
Diabetes	M F S B
High Blood Pressure	M F S B
Stroke	M F S B
Cancer	M F S B
Heart disease	M F S B
Thyroid disease	M F S B
Other inherited disease	M F S B

Your Social History

Do you or have you smoked? Y/N
If yes, how much _____ Quit date____
Do you drink alcohol? Y/N
If yes, how much _____
Do you use recreational drugs? Y/N

Form updated by	**Date**
_____	_____
_____	_____
_____	_____

For significant changes, please request an update form