PATIENT INFORMATION

Patient's Last Name: ___________________ First: _________________ Middle: ________________
□ Mr. □ Mrs. □ Miss □ Ms. □ Dr.

Marital Status (circle one)
Single / Mar / Div / Sep / Wid /Partnered

Is this your legal name? □ Yes □ No

If no, what is your legal name? __________________________

(Former Name): ____________________

DOB: ____________ Age: ______ Sex: □ M □ F Social Security No.: _______________

Street Address: ______________________ Home Phone No.: ___________________

P.O. Box: _____________ City: ___________________ State: _________ Zip Code: ______________

Email Address: ___________________________ Cell Phone: __________________________

Preferred Contact Number:______________________________

Employment Status: □ FT □ PT □ Self Employed □ FT Student □ Retired □Other

Occupation: _______________ Employer: ________________Employer Phone No.: _______________

How did you discover VisionCare? ____

HIPAA ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY POLICIES

I acknowledge that I received a copy of the Notice of Privacy Practices for this office. Pursuant to the information and rights presented in the Notice above you may write your request to restrict uses and/or disclosures of your protected health information on the back of this page.

____ ___________________________
Patient/Guardian signature Date

I authorize VisionCare Associates, P.C.to share my health and prescription information with the following individual(s):

1. _________________________ 2. __________________________

I authorize the release for medical records to insurance carriers for payments of medical services rendered to my dependant or myself. **I understand I am responsible for any amount not covered by my insurance when services are rendered.**

Signature: _______________________________________ Date: ______________

PLEASE FILL OUT SIDE 2

MEDICAL INFORMATION

Physician Name and Location:____

Diabetes: Y / N Type: ________ Date of Diagnosis: _______ Avg Sugar Level: _______ Med Dosage: __________

Allergies to Medications: ____

Health Conditions- *please check all that apply:*

___ High Blood Pressure	___ Arthritis	___ Kidney Disease	___ Stroke
___ Heart Disease	___ Depression	___ Prostate	___ Asthma
___ Water Retention	___ Anxiety	___ Blood Disorder	___ Emphysema
___ Hearing Disorder	___ Thyroid Disorder	___ Multiple Sclerosis	___ Hormone Replacement
___ Sinus	___ Cancer	___ Migraines	___ Pregnant
___ Skin Disorder	___ Ulcers/reflux	___ Seizures	____High Cholesterol

Previous Surgeries: ____

Eye Injuries: ____

Cigarette Use: ____________ **Alcohol Use:** ______________ **Other substances:** _____________

Patient History: Glaucoma Y / N Lazy Eye Y / N Cataracts Y / N Vision Loss Y / N

Retinal Problems Y / N

Family History: High Blood Pressure Y / N Diabetes Y / N Glaucoma Y / N

Macular Degeneration Y / N Cataracts Y/N

CURRENT MEDICATIONS

1. _____________________________ Reason: ___________________________________

2. _____________________________ Reason: ___________________________________

3. _____________________________ Reason: ___________________________________

4. _____________________________ Reason: ___________________________________

5. _____________________________ Reason: ___________________________________

I understand it is my responsibility to inform VisionCare of any changes to the above.

Signature: ______________________________ Date: _________________