EYE CO OPTOMETRY PATIENT INFORMATION

PATIENT NAME: _____ NICKNAME: _____ DOB: _____

SSN: _____ SEX: _____ EMAIL ADDRESS: _____

STREET ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____ WORK PHONE: _____

OCCUPATION: _____ PREF. CONTACT: _____

EMERGENCY CONTACT (NAME/RELATIONSHIP): _____ CONTACT #: _____

Our appointment scheduling system will send an email to remind you when you are due for your annual exam. In addition, you will receive an automated email to confirm your appointment as well as sending you a text message reminder. Do you consent to receiving text message reminder / alerts from our office? **(Initial) _____ YES / _____ NO**

Appointments should be canceled/rescheduled no later than 24 hours prior to your exam.
Any appointment cancellations or reschedules within 24 hours prior to your exam will be charged **a mandatory fee of $25** prior to rescheduling. The same applies for no shows. **(Initial) _____**

RELEASE OF INFORMATION

List family member(s) or designated representative(s) that you authorize access to your medical records, prescriptions, and/or purchases. You must submit any changes to this authorization in writing.

NAME: _____ RELATION: _____ DOB: _____
NAME: _____ RELATION: _____ DOB: _____

MEDICAL INSURANCE INFORMATION

MEDICAL INSURANCE PROVIDER: _____ MEMBER ID: _____
PRIMARY INSURED NAME: _____ DOB: _____ SSN: _____

VISION INSURANCE INFORMATION (CIRCLE ONE)

VSP EYEMED DAVIS PHYS. EYECARE SUPERIOR TRICARE PRIME OTHER: _____
PRIMARY INSURED NAME: _____ DOB: _____ SSN: _____

VISION CORRECTION HISTORY

Do you wear glasses?	YES NO	If yes, what for:	DISTANCE	READING
Have you worn contacts before?	YES NO	If yes, what brand:	_____	
Are you interested in trying contacts today?	YES NO			
How often do you change contact lenses?	DAILY WEEKLY 2 WEEKS MONTHLY			
What contact lens solution do you use?	_____			

ACKNOWLEDGEMENT OF HIPAA PRIVACY POLICY

I, _____ **(PRINT FULL NAME OF PATIENT/LEGAL REPRESENTATIVE)**, have been presented with the Notice of Privacy Policy and have been offered a copy of this receipt.

I will also be responsible for any financial obligations not covered by my insurance company.

_____ _____
Signature of Patient or Legal Representative Date

MEDICAL HISTORY

PRIMARY CARE PHYSICIAN: _____ OFFICE PHONE: _____
PRACTICE NAME/LOCATION: _____ OFFICE FAX: _____

	Self	Family		Self	Family
Diabetes	_____	_____	Retinal Detachment	_____	_____
High Blood Pressure	_____	_____	Eye Surgery	_____	_____
Cataracts	_____	_____	Lazy Eye	_____	_____
Heart Problems	_____	_____	Double Vision	_____	_____
Respiratory Problems	_____	_____	Blindness	_____	_____
Thyroid Problem	_____	_____	Head/Eye Injury	_____	_____
Glaucoma	_____	_____	Headache	_____	_____
Loss of Vision	_____	_____	Cancer	_____	_____

List any surgeries/year: _____
_____

MEDICATION LIST

List all medications you are currently taking (include prescription and non-prescription medications):

MEDICATION NAME	DOSAGE	FREQUENCY	REASON FOR TAKING
(Example: Metformin	*500 mg*	*1 pill twice daily*	*Diabetes)*
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

ALLERGIES TO MEDICATION

MEDICATION NAME	REACTION TO MEDICATION
(Example: Penicillin)	*(Rash)*
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____