PATIENT INFORMATION
Please print legible

Name:_____ DOB:_____ Gender: □M □F
FIRST, MIDDLE INITITAL, LAST
Street:_____ Age:_____
City:_____ State:_____ Zip:_____
Home Phone:_____ Work/Daytime Phone:_____
Marital Status: □ Single □ Married □ Widowed □ Divorced □ Separated
Employer/School:_____ Occupation(or school grade):_____
Spouse's Name: _____ Work Phone: _____
If a Child, Parent's Name:_____ Work Phone:_____
E-Mail Address:_____ Cell Phone: _____
Is this your first visit to our office? YES NO How did you hear about us? _____
How would you like us to contact you in the future? □Email □Postcard □Telephone □Text Msg
Is this Exam for Contact Lenses? □Possible □Yes □ No
Have you worn Contact Lenses before? □Possible □Yes □ No
Are you interested in LASIK surgery? □Possible □Yes □ No
Primary Care Physician/Group: _____ Phone:_____
Date of last physical exam: _____ Does your PCP request eye reports? □Yes □ No

Insurance Types
□ TRICARE □ MEDICAID □ MEDICARE □ MAJOR MEDICAL □ VISION INSURANCE

Insurance Company Name: _____ Member ID # _____
Secondary Insurance (if applicable): _____ Member ID # _____
Other Insurance (if applicable): _____ Member ID # _____
Please have your insurance card(s) handy so we can make a copy

Please Fill Out the Names of the Family Members in your House
**Information regarding family members is important because some vision problems are hereditary. All family information is kept confidential.*

Patient Here?	Name	Relation	Date of Birth	Last Exam
YES NO				
YES NO				
YES NO				
YES NO				
YES NO				
YES NO				
YES NO				

Authorization: I authorize any holder of medical or other information about me to release any information needed for this claim to the Social Security Administration and Health Care Financial Administration, its intermediaries or carriers, the billing agent of the supplier, Medicaid, an Insurance Company, or third party payor. I understand that I am responsible for amounts, deductibles, and charges not reimbursed by Medicare, Medicaid, my insurance company, or a third party payor. I permit a copy of this authorization to be used in place of the original signature and request payment of medical insurance benefits be paid to Vista Vision.
Advance Beneficiary Notice: I further understand that Medicaid does not pay for Vision Therapy (code 92065); Medicare does not pay for a Refraction (code 92015); and Medicaid, Medicare and Tricare do not pay for contact lens fittings (code 92310).
Privacy Notice: I have been offered a copy of the office's privacy notice or have read a copy that is on display.

Patient/Responsible Party's Signature: _____

Patient's Name: _____ **Date:** _____

MEDICAL INFORMATION (PLEASE CHECK ALL THAT APPLY)

DO YOU CURRENTLY:

WEAR GLASSES **YES** **NO** IF YES, WHAT ARE THE AGE OF YOUR CURRENT GLASSES _____

WEAR CONTACT LENSES **YES** **NO** IF YES, WHAT BRAND OF CONTACTS _____

HAVE YOU HAD:

CATARACT SURGERY **YES** **NO** EYE MUSCLE SURGERY **YES** **NO** LASIK/PRK SURGERY **YES** **NO**
RETINAL SURGERY **YES** **NO** TRAUMATIC EYE INJURY **YES** **NO**

VISION HISTORY

Do you or anyone in your immediate family have:

			RELATION
Amblyopia/Lazy Eye	YES	NO	_____
Blindness	YES	NO	_____
Cataracts	YES	NO	_____
Crossed/Turned Eyes	YES	NO	_____
Diabetic Retinopathy	YES	NO	_____
Double Vision	YES	NO	_____
Flashes/Floaters	YES	NO	_____
Glaucoma	YES	NO	_____
Macular Degeneration	YES	NO	_____
Retinal Detachment	YES	NO	_____
Other _____	YES	NO	_____

SOCIAL HISTORY

DO YOU SMOKE NO YES, _____ PACK PER DAY
ALCOHOL USE NO YES, _____ DRINKS PER WEEK

FEMALES: ARE YOU

PREGNANT: NO YES, _____ WEEKS NURSING: YES NO

ALLERGENS:

Animal Dander **YES** **NO**
Environmental **YES** **NO**

DRUG ALLERGIES: NO YES. list below

LIST ALL CURRENT MEDICATIONS

YOUR CURRENT MEDICAL HISTORY: Circle all that apply.

CARDIOVASCULAR		
Elevated Cholesterol	YES	NO
Heart Disease	YES	NO
High Blood Pressure	YES	NO
CONSTITUTION		
Weight Gain/Loss	YES	NO
EAR, NOSE, THROAT		
Sinuses	YES	NO
ENDOCRINE		
Diabetes	YES	NO
Thyroid Disorder	YES	NO
GASTRONITESTINAL		
Acid-Reflux	YES	NO
Crohn's Disease	YES	NO
Hepatitis	YES	NO
GENITOURINARY		
Kidney Stones	YES	NO
Genitals/Kidney/Bladder	YES	NO
Sexually Trans. Disease	YES	NO
HEMATOLOGIC/LYMPHATIC		
Anemia	YES	NO
Leukemia	YES	NO
Sickle Cell Trait/Disease	YES	NO
OTHER:		
History of Cancer	YES	NO

IMMUNOLOGIC		
Herpes Simplex/Zoster	YES	NO
HIV Positive	YES	NO
Sarcoidosis	YES	NO
INTEGUMENTARY		
Rosacea	YES	NO
Lupus	YES	NO
MUSCULOSKELETAL		
Rheumatoid Arthritis	YES	NO
Osteoporosis	YES	NO
NEUROLOGICAL		
Headache	YES	NO
Migraines	YES	NO
Seizures	YES	NO
PSYCHIATRIC		
ADD	YES	NO
Anxiety Disorder	YES	NO
Depression/Bipolar	YES	NO
RESPIRATORY		
Asthma	YES	NO
COPD	YES	NO
Sleep Apnea	YES	NO

OTHER: _____