CONFIDENTIAL

## PATIENT INFORMATION

*Thank you for choosing Vision Plus for your eyecare needs. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.*
*(Please Print)*

Name ______________________________________ Birthdate ______/______/______
First MI Last

Address ________________________________________________________________

City__________________ State ________ Zip ______________

S.S.#______________________ Email Address ____________________________________

Home# ________________________Mobile# ______________________ Work# ________________

You or your parents' employer __________________________ Occupation ______________________

Business Address __________________________________City ____________ State ______ Zip______

Spouse or parent's name _______________________________________

Person to contact in case of emergency ____________________________Phone#____________________

## RESPONSIBLE PARTY

Name of person responsible for this account ______________________________________________

Relationship to patient __________________________ Phone # _____________________________

Address __________________________________________________________________

City ______________ State _______ Zip _______

Name of employer __________________________________Work#_________________________

## INSURANCE INFORMATION

*VISION*

Name of insured __________________________________ Relationship to patient ______________

Birthdate___________________________ Social Security#__________________________________

Insurance Co. ____________________________________ ID#______________________________

Group# __________________________________ Employer# ______________________________

DO YOU HAVE ADDITIONAL INSURANCE?

☐ NO ☐ YES IF YES,COMPLETE THE FOLLOWING:

*MEDICAL*

Name of insured __________________________________ Relationship to patient ______________

Birthdate___________________________ Social Security#__________________________________

Insurance Co. ____________________________________ ID#______________________________

Group# __________________________________ Employer# ______________________________

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# HEALTH HISTORY

Name ______________________________ Age __________

Reason for today's exam ______________________________

Date of last exam ____________________ Name of eye doctor ____________________

Do you or anyone in your immediate family have a history of the following?

- ☐ Diabetes
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Blindness
- ☐ Thyroid
- ☐ Heart Condition
- ☐ High blood pressure
- ☐ Turned or lazy eye

Please check any of the following conditions that apply to you:

- ☐ Frequent headaches
- ☐ Allergies
- ☐ Drug allergies
- ☐ Sinus trouble
- ☐ Pregnant
- ☐ Have given birth in the last 6 months

Have you ever had any of the following conditions involving your eyes?

- ☐ Eye surgery
- ☐ Eye injury
- ☐ Medical treatment
- ☐ Severe pain
- ☐ Sensitivity to light
- ☐ Floaters or spots
- ☐ Poor distance vision
- ☐ Poor near vision
- ☐ Eye infection or disease
- ☐ Double vision
- ☐ Eye strain
- ☐ Eyes burn, itch, or water

Do you currently wear glasses? ☐ Yes ☐ No

When do you wear glasses?

- ☐ All the time
- ☐ Work safety
- ☐ Reading/near work
- ☐ Computer work
- ☐ Distance tasks only
- ☐ Other, please explain __________

Have you ever worn contacts? ☐ Yes ☐ No

Are you interested in wearing contact lenses? ☐ Yes ☐ No

If so, what style?

- ☐ Soft
- ☐ Extended Wear
- ☐ Gas Permeable
- ☐ Bifocal
- ☐ Tinted
- ☐ Astigmatic
- ☐ Disposable
- ☐ Unsure

Do you work at a computer or video display terminal? ☐ Yes ☐ No

What hobbies or sports do you participate in? ______________________________

X ____________________________________________________________

SIGNATURE OF PATIENT (Or parent if minor) DATE