PATIENT HISTORY FORM

VisionCare

GENERAL INFORMATION

First, MI, Last, Preferred Name

Street Address

City, State, Zip

Phone, Type

Phone 2, Type

Email

Preferred Contact Method Phone 1 | Phone 2 | Email | Text | Other (please explain)

Date of Birth Patient Social Security Number

Patient Sex Male | Female

Primary Care Physician

Occupation/Employer full-time | part-time

Marital Status Married | Single | Divorced | Legally Separated | Widowed

Primary Language, Race, and Ethnicity I refuse to disclose this info (initial here) ☐

Mother's Name / Birthday / Primary Phone Number:

Father's Name / Birthday / Primary Phone Number:

Family Members / Siblings:

How did you hear of our office? (Circle Primary Source) WKYM | Z93 | WANY | The Outlook | Clinton Co News | Phone Book | Internet

Were you referred to our office by a doctor/patient or friend? Yes | No **If so, who?**

EYE HISTORY/CURRENT SYMPTOMS

Date of Last Eye Exam

Currently Wear Glasses? Yes | No

Currently Wear Contacts? Yes | No

If yes, what brand of contacts:

How many hours a day do you use a computer?

Do you regularly wear sunglasses? Yes | No

Do you use over the counter readers? Yes | No

Do you drive? Yes | No

Do you have visual difficulty when driving? Yes | No

If Yes, Please explain:

Have you or a family member experienced, or been treated for, any of the following? Circle all that apply. ☐ **None applicable**

Cataracts	myself	mother	father	grandparents	other family
Crossed Eye	myself	mother	father	grandparents	other family
Glaucoma	myself	mother	father	grandparents	other family
LASIK or RK	myself	mother	father	grandparents	other family
Lazy Eye	myself	mother	father	grandparents	other family
Macular Degener.	myself	mother	father	grandparents	other family
Retinal Detach.	myself	mother	father	grandparents	other family

Other Eye Conditions?

Are you currently experiencing, or have experienced, any of the following? Circle all that apply:

Blurry Vision – Distance	Blurry Vision – Near	Blurry Vision – Computer	Burning
Discharge	Double Vision	Dryness	Excess Tearing/Watering
Eye Infection	Eye Pain or Soreness	Floaters or Spots	Halos
Headaches	Itching	Light Flashes	Light Sensitivity
Redness	Sandy or Gritty Feeling	Other_____	

INSURANCE/PAYMENT INFORMATION

Do you have vision insurance? Yes | No Do you have medical insurance? Yes | No

How will you be paying today? Cash | Check | Credit Card | Gift Certificate

If patient is a minor, what parent/guardian's name would you like them primarily listed under?_____

Have you or a family member experienced, or been treated for, any of the following? Circle all that apply. ☐ **None**

AIDS/HIV	myself	mother	father	brother	sister	grandparent	aunt	uncle
Allergies	myself	mother	father	brother	sister	grandparent	aunt	uncle
Arthritis	myself	mother	father	brother	sister	grandparent	aunt	uncle
Asthma	myself	mother	father	brother	sister	grandparent	aunt	uncle
Blood/Lymph	myself	mother	father	brother	sister	grandparent	aunt	uncle
Cancer	myself	mother	father	brother	sister	grandparent	aunt	uncle
Diabetes	myself	mother	father	brother	sister	grandparent	aunt	uncle
Ears/Nose/Throat	myself	mother	father	brother	sister	grandparent	aunt	uncle
Gastrointestinal	myself	mother	father	brother	sister	grandparent	aunt	uncle
Heart Disease	myself	mother	father	brother	sister	grandparent	aunt	uncle
High Blood Press	myself	mother	father	brother	sister	grandparent	aunt	uncle
High Cholesterol	myself	mother	father	brother	sister	grandparent	aunt	uncle
Kidney Disease	myself	mother	father	brother	sister	grandparent	aunt	uncle
Lupus	myself	mother	father	brother	sister	grandparent	aunt	uncle
Neurological	myself	mother	father	brother	sister	grandparent	aunt	uncle
Psychiatric	myself	mother	father	brother	sister	grandparent	aunt	uncle
Seizures	myself	mother	father	brother	sister	grandparent	aunt	uncle
Skin Conditions	myself	mother	father	brother	sister	grandparent	aunt	uncle
Stroke	myself	mother	father	brother	sister	grandparent	aunt	uncle
Thyroid	myself	mother	father	brother	sister	grandparent	aunt	uncle

Do you currently take any medications: Yes | No **(If you have a list with you, we can scan it so no need to write it)**

Are you allergic to any medications? Yes | No **If yes, please list below:**

Height: **Weight:** I refuse to disclose this info (initial here) ☐ **Are you pregnant or nursing?** Yes | No

Do you use tobacco products? Yes | No **If yes, what kind/how much/how long?**

If no, did you ever? Yes | No

Have you ever been exposed to or infected with (please circle)? Gonorrhea | Hepatitis | HIV | Syphilis

OFFICE POLICIES

1. Payment for services is expected at the time the service is rendered. Glasses and/or contact lenses will be ordered after half down of product total is received in our office and must be paid in full before they can leave our office. We are happy discuss payment plans if you have a need.
2. Please present all insurance cards to our receptionist at each visit so we can verify coverage and benefits. Authorization and Assignment: I hereby authorize the release of medical information to my insurance company and assign to Vision Care PSC and Dr. Matt Hesse all payment for services rendered to me or my dependents. This assignment will remain in effect until revoked by me in writing. A copy of this authorization may be used in place of the original. Insurance claims will be filed only if our office is a participating provider for my plan; however, it is my responsibility to know my covered benefits. Should my insurance not reimburse the office in a timely manner, I am responsible for the balance.
3. In accoradance with KY State Law, eyeglass prescriptions are valid for two (2) years. In order to protect the health of your eyes and in accordance with KY State Law, contact lens prescriptions are valid for one (1) year only.
4. The undersigned understands and agrees that the account balance is due, in full, upon receipt of a statement if received. If the account is not paid in full within 90 days from the date the statement is received, the undersigned agrees to be liable for all costs of collection, including attorney's fees and court costs

If you have any questions concerning any of the above policies, please see the receptionist for further explanation. **Additionally, I acknowledge that I have had the opportunity to review the notice of privacy practices for Vision Care.**

(Sign) _____ (Date) _____