Visionary Eye Care Associates, LLC

Confidential Patient History/Information

Name: _____ Age: _____ Male / Female Date of Birth: ____/____/____

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____ Occupation: _____ Sports / Hobbies: _____

Purpose of today's visit (routine, eye irritation, lost glasses, etc.): _____

Primary Physician: _____ Address: _____ Phone: _____

Insurance: (circle one):

Aetna	AmeriHealth Administrators		Coresource
Davis Vision	Horizon BC/BS		Medicare
MES Vision	Railroad Medicare		Spectera
Tricare Prime	US Family	VBA	VSP

Primary Insured's Name: _____ **Primary Insured's** Social Security # (last 4 digits): _____

Primary Insured's Date of Birth: _____/_____/_____ Relationship to Patient (circle one): Self Spouse Parent Other

Please indicate whether you or any blood relatives have/had any of the following? S=Self F=Family

_____ Arthritis	_____ Pregnant, currently	_____ Eye Disease
_____ Asthma/Lung Disease	_____ Thyroid problems	_____ Eye Injury
_____ Cancer/Tumor	_____ Dry Eyes	_____ Eye Surgery
_____ Diabetes	_____ Amblyopia (lazy eye)	_____ Flashes/Floaters/Spots
_____ Heart Disease	_____ Macular Degeneration	_____ Glaucoma
_____ High Blood Pressure	_____ Cataracts	_____ Strabismus (eye turn)

Are you taking any medications? _____ If so, please list : _____
Are you allergic to any medications? _____ If so, please list: _____
Are you a smoker? (circle one) Yes Never a smoker Former smoker
Date of your last eye exam: _____ Where?: _____
Do you or have you ever worn glasses?: _____ Circle one: Single vision Bifocal Progressive
Do you or have you ever worn contact lenses?: _____ Circle one: Soft Astigmatic Gas Permeable Other
Are you interested in contact lenses? _____ Are you interested in Lasik?: _____
Any other information you feel we should know for our records:_____
_____

Authorization Signature: I authorize the release of any medical records or other information necessary to process this claim. I authorize payments of medical/optical benefits to Visionary Eye Care Associates, LLC for Optometric Services.

** Please note that a returned check fee is $25. Thank you.

Signature: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

** You may refuse to sign this acknowledgement **

I, _____, have received/read a copy of this office's Notice of Privacy Practices.

Signature: _____ Date: _____

For office use only:

**We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:
____ Individual refused to sign ____ Emergency situation prohibited obtaining signature ____ Communication barriers prohibited obtaining signature ____
Other: _____