

**Welcome to COMPLETE VISION CARE**

Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_ Today's date: \_\_\_\_\_  
 Address: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
 \_\_\_\_\_ SSN: \_\_\_\_\_

Employer (if applicable): \_\_\_\_\_  
 Occupation (if student, what grade?): \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_  
 \*\*Do you live in a skilled nursing facility? YES NO

Spouse/Parent Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 \_\_\_\_\_ SSN: \_\_\_\_\_

Employer and Occupation: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

**INSURANCE INFORMATION**

Insured Person's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
 \_\_\_\_\_ SSN: \_\_\_\_\_

Medical Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_  
 Do you participate in a Medicare HMO: \_\_\_\_\_

Vision Insurance Company (if applicable): \_\_\_\_\_

Please list the name of your **Primary Care Physician**: \_\_\_\_\_

<b>FAMILY HISTORY</b> (Have any family members had these problems?)				<i>Relation to patient</i>
<b>Ocular:</b>	Glaucoma	<b>Y</b>	<b>N</b>	
	Macular degeneration	<b>Y</b>	<b>N</b>	
	Retinal detachment	<b>Y</b>	<b>N</b>	
	Color blindness	<b>Y</b>	<b>N</b>	
	Other (please list):			
<b>Medical:</b>	High blood pressure	<b>Y</b>	<b>N</b>	
	Diabetes mellitus	<b>Y</b>	<b>N</b>	
	Other (please list):			

<b>SOCIAL HISTORY</b>			
Do you smoke?	<b>Y</b>	<b>N</b>	<input type="checkbox"/> <1 pack/day <input type="checkbox"/> 1+ packs/day
Do you drink alcohol?	<b>Y</b>	<b>N</b>	<input type="checkbox"/> Occasionally <input type="checkbox"/> Daily <input type="checkbox"/> 3+ drinks per day
Do you use drugs?	<b>Y</b>	<b>N</b>	
Do you use a computer?	<b>Y</b>	<b>N</b>	<input type="checkbox"/> <2 hrs/day <input type="checkbox"/> 2-4 hrs/day <input type="checkbox"/> 4+ hrs/day
Are you pregnant or nursing?	<b>Y</b>	<b>N</b>	

**PAST MEDICAL HISTORY**

**Medications** (Please list any medications you are taking, prescription and OTC): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Are you allergic to any medications (please list): \_\_\_\_\_

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**REVIEW OF BODY SYSTEMS** (please fill out the following Health History as it pertains to you, the patient)

<p><b>Allergy/Immunology</b> <input type="checkbox"/> none</p> <input type="checkbox"/> environmental allergies <input type="checkbox"/> drug allergy _____ <input type="checkbox"/> rheumatoid arthritis <input type="checkbox"/> lupus <input type="checkbox"/> other: _____	<p><b>Eyes</b> <input type="checkbox"/> none</p> <input type="checkbox"/> glaucoma <input type="checkbox"/> cataract <input type="checkbox"/> macular degeneration <input type="checkbox"/> surgery/injury <input type="checkbox"/> blurred vision <input type="checkbox"/> double vision <input type="checkbox"/> other: _____	<p><b>Musculoskeletal</b> <input type="checkbox"/> none</p> <input type="checkbox"/> fibromyalgia <input type="checkbox"/> muscular dystrophy <input type="checkbox"/> osteoarthritis <input type="checkbox"/> ankylosing spondylitis <input type="checkbox"/> other: _____
<p><b>Cardiovascular</b> <input type="checkbox"/> none</p> <input type="checkbox"/> heart disease <input type="checkbox"/> high blood pressure <input type="checkbox"/> stroke <input type="checkbox"/> vascular disease <input type="checkbox"/> other: _____	<p><b>Gastrointestinal</b> <input type="checkbox"/> none</p> <input type="checkbox"/> Crohn's disease <input type="checkbox"/> colitis <input type="checkbox"/> ulcer <input type="checkbox"/> acid reflux <input type="checkbox"/> hepatitis <input type="checkbox"/> other: _____	<p><b>Neurologic</b> <input type="checkbox"/> none</p> <input type="checkbox"/> multiple sclerosis <input type="checkbox"/> epilepsy <input type="checkbox"/> Alzheimer's disease <input type="checkbox"/> Parkinson's disease <input type="checkbox"/> stroke <input type="checkbox"/> other: _____
<p><b>Constitutional</b> <input type="checkbox"/> none</p> <input type="checkbox"/> weight loss <input type="checkbox"/> fever <input type="checkbox"/> fatigue <input type="checkbox"/> other: _____	<p><b>Genitourinary</b> <input type="checkbox"/> none</p> <input type="checkbox"/> STD <input type="checkbox"/> kidney <input type="checkbox"/> enlarged prostate <input type="checkbox"/> other: _____	<p><b>Psychiatric</b> <input type="checkbox"/> none</p> <input type="checkbox"/> depression <input type="checkbox"/> anxiety <input type="checkbox"/> schizophrenia <input type="checkbox"/> other: _____
<p><b>Ears, Nose, Throat</b> <input type="checkbox"/> none</p> <input type="checkbox"/> respiratory infection <input type="checkbox"/> ear ache <input type="checkbox"/> runny nose <input type="checkbox"/> sore throat <input type="checkbox"/> other: _____	<p><b>Hematology/Lymphatic</b> <input type="checkbox"/> none</p> <input type="checkbox"/> anemia <input type="checkbox"/> leukemia <input type="checkbox"/> bleeding disorder <input type="checkbox"/> other: _____	<p><b>Respiratory</b> <input type="checkbox"/> none</p> <input type="checkbox"/> smoker <input type="checkbox"/> asthma <input type="checkbox"/> bronchitis <input type="checkbox"/> emphysema/COPD <input type="checkbox"/> other: _____
<p><b>Endocrine</b> <input type="checkbox"/> none</p> <input type="checkbox"/> non-insulin-dependent diabetes mellitus <input type="checkbox"/> insulin-dependent diabetes mellitus <input type="checkbox"/> thyroid dysfunction <input type="checkbox"/> other: _____		<p><b>Integumentary (skin)</b> <input type="checkbox"/> none</p> <input type="checkbox"/> eczema <input type="checkbox"/> rosacea <input type="checkbox"/> psoriasis <input type="checkbox"/> other: _____

\*May we release all information to anyone at your home telephone number? YES NO  
 If no, with whom may we leave a message? \_\_\_\_\_

**I understand that my insurance carrier may pay less than the actual bill for services. I understand that I am responsible for payment of all services rendered on my behalf or my dependents.**

I understand that failure to pick up any item that I have ordered for myself or my dependents without notifying the office to cancel the order within 24 hours of ordering will be payable in full and that any special order items are non-cancelable.

**Late Charges:** If I do not pay the entire new balance within 25 days of the monthly billing date, a one dollar (\$1.00) billing fee will be assessed each month (if allowed by law). **I realize that failure to keep this account current may result in you, Complete Vision Care, being unable to provide additional services, except for emergencies or where there is prepayment for those additional services.** In the case of default on payment of the account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

X

Signature of patient or personal representative (and relation to patient)

Date