VISION SPECIALISTS

Last Name: _____ First Name: _____Middle Initial: _____

Street Address: _____ Apt#: _____

City: _____ State: _____ Zip Code: _____

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

☐ YES, I would like to receive appointment reminders via text message.

Email Address: _____

Date of Birth: _____ Social Security # (last 4 digits):_____ Gender: ▫ M ▫ F

Marital Status: _____ Race: _____ Ethnicity: _____ Preferred Language: _____

Employer: _____Occupation: _____

Family Physician/Office: _____

Who can we thank for referring you to our office? _____

Emergency Contact Information

Name: _____

Relationship: _____ Phone: _____

Insurance Information

Primary Card Holder's Name: _____ Relationship: _____

Address: _____ Date of Birth: _____

Social Security # (last 4 digits): _____Contact Phone #: _____ Employer: _____

Notice of Privacy Practices, Authorization to Release Information to Insurance Company, & Acknowledgement of Responsibility for Payment

I acknowledge I have been offered or received a copy of this practice's NOTICE OF PRIVACY PRACTICES. I understand that Vision Specialists of Council Bluffs (VSCB) is a healthcare provider and may share my health information for treatment, payment, and healthcare operations.

I hereby assign all medical benefits (to which I am entitled) to the doctor caring for me. VSCB will file insurance coverage for me if I provide them with a copy of my current insurance card. This includes any health plans in which I am enrolled. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not they are paid by my insurance. I hereby authorize the holder of my medical and patient registration records to release any information needed to process my insurance claims. I understand that I am the guarantor of this account. A copy of my medical records can be requested in writing and will be provided to me or whomever I designate for $15.00. I do acknowledge that there is a $25.00 fee for returned checks. I am aware that if I do not have insurance coverage, I will be responsible for payment. Payment is due at the time of service.

Patient/Guarantor Signature: _____ Date: _____

Patient History

Reason for today's visit?

_____

_____

Date of last eye exam? _____

Who performed last exam? _____

Currently wear glasses? ☐ Yes ☐ No

Currently wear contacts? ☐ Yes ☐ No

Have you or a family member (list relationship) experienced or been treated for any of the following?

Cataracts ☐ me ☐ family _____

Crossed Eye ☐ me ☐ family_____

Lazy Eye ☐ me ☐ family _____

Glaucoma ☐ me ☐ family _____

LASIK or RK ☐ me ☐▫ family _____

Macular Degeneration ☐ me ☐ family _____

Retinal Detachment ☐ me ☐ family _____

Other _____

Eye Injuries _____

Are you currently experiencing, or have recently experienced, any of the following?

☐ Blurry Vision (near or distance)

☐ Loss of Vision

☐ Double Vision

☐ Glare / Halos

☐ Light Sensitivity

☐ Flashes of Light

☐ Floaters / Black spots

☐ Tired Eyes

☐ Tearing / Watering

☐ Itching

☐ Redness

☐ Dryness

☐ Headaches

Do you work at a computer? ☐ Yes ☐ No

Do you plan on getting glasses today? ☐ Yes ☐ No

Do you plan on getting contacts today? ☐ Yes ☐ No

Have you or a family member (LIST RELATIONSHIP) experienced or been treated for any of the following?

ADD/ADHD (circle) ☐ me ☐ family _____

AIDS/HIV ☐ me ☐ family _____

Allergies ☐ me ☐ family _____

Anxiety ☐ me ☐ family _____

Arthritis ☐ me ☐ family _____

Asthma ☐ me ☐ family _____

Blood/Lymph Disorder ☐ me ☐ family _____

Cancer (**List Type**) ☐ me ☐ family _____

Depression ☐ me ☐ family _____

Diabetes ☐ me ☐ family _____

GI Conditions ☐ me ☐ family _____

Heart Disease ☐ me ☐ family _____

High Blood Pressure ☐ me ☐ family _____

High Cholesterol ☐ me ☐ family _____

Kidney Disease ☐ me ☐ family _____

Lupus ☐ me ☐ family _____

Neurological Conditions ☐ me ☐ family _____

Psychiatric Disorder ☐ me ☐ family _____

Seizures ☐ me ☐ family _____

Skin Conditions ☐ me ☐ family _____

Stroke ☐ me ☐ family _____

Thyroid Dysfunction ☐ me ☐ family _____

Other ☐ me ☐ family_____

Do you have any known allergies to medications?

▫Yes ▫ No If yes, please explain:

_____

Current Medications (prescription, OTC, vitamins)

_____

_____

_____

Height: _____ **Weight:** _____

Are you pregnant or nursing? _____

Do you smoke or chew tobacco? Which?_____

Do you drink alcohol? _____

Do you use recreational drugs? _____