Welcome to Clear Vision Optometry

Patient Information

Name_____ Age_____ Birth date_____
last first

Address_____ City_____ State _____Zip_____

SSN_____ Home Phone#_____ Work / Cell Phone#_____

In case of an emergency, contact _____Phone #_____

Insurance information

Name of insured_____ Relationship to patient_____

Birth date _____ Social security #_____Date of employment_____

Name of employer _____ Address_____ Phone #_____

Health History

Date of last eye exam_____ Name of doctor_____ Phone #_____

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

[ ] Diabetes [ ] Blindness [ ] High blood pressure [ ] Thyroid disease
[ ] Turned or lazy eye [ ] Glaucoma [ ] Heart condition

Please check any of the following that apply to you:

[ ] Frequent headaches [ ] Drug allergies [ ] Pregnant [ ] Allergies
[ ] Sinus trouble [ ] Alcohol / Tobacco use [ ] Drug use

Please list all medications you are currently taking: _____

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

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

Do you currently wear glasses? [ ] yes [ ] No

When do you wear glasses?

[ ] All the time [ ] Distance [ ] Reading / near [ ]Computer work
[ ] Other, please explain: _____

Have you ever worn contact lenses? [ ] Yes [ ] No

If no, are you interested in wearing contact lenses? [ ] Yes [ ] No

Do you work at a computer or video display monitor? [ ] Yes [ ] No

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the eye doctor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my dependents during the period of such eye care to third parties payers and / or health practitioners. I authorize and request my insurance company to pay directly to the eye doctor or ophthalmic group insurance benefits otherwise payable to me. I understand that my eye care insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. **I acknowledge that I have received a notice of the privacy practices as required by HIPAA privacy standard.**

X_____Date_____