VISION *One*

Welcome To Our Office

❑ Mr.
❑ Mrs.
❑ Ms. _____ Social Security #: _____/____/_____
FIRST MI LAST (NICKNAME)

Street: _____ Birthdate: ___/___/___ Age: _____ ❑ M ❑ F

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cellular: _____

E-mail: _____

Occupation or Grade: _____ Employer or school: _____

Spouse or Parents Name: _____ Spouse or Parents Work Phone: _____

In Case of Emergency Notify: _____ Phone: _____

Whom may we thank for referring you to our office: _____

Or were you introduced by: **Phone Book:** ❑ Impact ❑ Qwest ❑ Yellow Book
❑ Insurance Company ❑ Location ❑ Search Engine _____

WHAT IS THE MAJOR PURPOSE OF THIS VISIT? _____

Date of Last Exam: ____/____/____ **Where?** _____

DO YOU CURRENTLY WEAR CONTACT LENSES? ❑ Yes ❑ No BRAND: _____

HAVE YOU EVER WORN CONTACT LENSES? ❑ Yes ❑ No

ANY PROBLEMS WITH YOUR PRESENT CONTACT LENSES? ❑ Yes ❑ No ❑ N/A

If yes, please explain _____

ANY PROBLEMS WITH YOUR PRESENT GLASSES? ❑ Yes ❑ No ❑ N/A

If yes, please explain _____

ARE YOU INTERESTED IN ANY OF THE FOLLOWING? ❑ Contact Lenses ❑ Sunglasses ❑ Lasik
❑ Colored Contacts

SPECIAL INTERESTS: Hobbies, Sports, Occupational Needs _____

_____

INSURANCE INFORMATION – PLEASE PRESENT CARD AT TIME OF SERVICE

_____ _____ _____
Medical Insurance Vision Insurance Insured's Name

_____ _____
Insured's Social Security Number Relationship to patient

PAYMENT IS DUE AT TIME OF SERVICE

I request that payment of insurance benefits be made on my behalf to Vision One for any services furnished me by Vision One.
I authorize any holder of medical information about me to release to my insurance carrier and its agents any information needed to determine these benefits or the benefits payable for related services.
I authorize and agree to pay for all services rendered to me not covered by Medicare or other insurance.

Signature: _____ **Date:** _____

ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING?

- ☐ Blurred Far Vision
- ☐ Blurred Near Vision
- ☐ Redness
- ☐ Itching
- ☐ Tearing
- ☐ Burning
- ☐ Pain In / Around Eye
- ☐ Flashes of Light
- ☐ Floaters
- ☐ Headaches
- ☐ Double Vision
- ☐ Sensitivity to Light
- ☐ Head Trauma

Other: _____

EYE DISEASES: Do you now, or have you *ever* had, any of the following eye diseases?

Yes	No		Yes	No		Yes	No	
☐	☐	Cataract	☐	☐	Diabetic retinopathy	☐	☐	Lazy eye
☐	☐	Glaucoma	☐	☐	Macular degeneration	☐	☐	Injury
☐	☐	Detached retina	☐	☐	Crossed eyes	☐		Other _____

PAST ILLNESSES/INJURIES/SURGERIES: Please list all *past* major illnesses, injuries or surgeries you have had.

_____

_____

CURRENT CONDITIONS: Do you *currently* have any of the following conditions? *(check all boxes that apply)*

Yes	No		Yes	No		Yes	No	
☐	☐	☐ Fever ☐ Weight loss	☐	☐	High Cholesterol	☐	☐	☐ Stroke ☐ Other neurological disease
☐	☐	☐ Ears ☐ Mouth ☐ Throat problems	☐	☐	☐ Diabetes ☐ Thyroid problems	☐	☐	Psychiatric problems
☐	☐	☐ Nose ☐ sinus problems	☐	☐	☐ Stomach ☐ Intestinal problems	☐	☐	☐ Blood disorders ☐ Prolonged bleeding
☐	☐	High blood pressure	☐	☐	☐ Kidney ☐ Urinary ☐ Genital disease	☐	☐	HIV/AIDS
☐	☐	Irregular heart beat	☐	☐	Pregnant	☐	☐	Seasonal allergies
☐	☐	Other heart disease	☐	☐	☐ Joint pain ☐ Muscle pain	☐	☐	Smoking ☐ Never
☐	☐	☐ Asthma ☐ Emphysema	☐	☐	Skin disease	☐	☐	Alcohol ☐ Abuse ☐ Social
☐	☐	Other lung disease	☐	☐	Headache	☐	☐	Substance abuse

Do you have any drug sensitivities / allergies? ☐ Yes ☐ No _____

Are you currently under a physician's care? ☐ Yes ☐ No Family Physician _____

CURRENT MEDICATIONS: PRESCRIPTION OR OVER THE COUNTER:

Medications: _____ For: _____ Medications: _____ For: _____

Medications: _____ For: _____ Medications: _____ For: _____

Others: _____

FAMILY HISTORY: Have your *parents, grandparents or siblings* had any of the following diseases?

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Blindness	☐	☐	Macular degeneration	☐	☐	Heart disease	☐	☐	Diabetes
☐	☐	Cataract	☐	☐	Retinal detachment	☐	☐	Stroke	☐	☐	Cancer
☐	☐	Glaucoma	☐	☐	High blood pressure	☐	☐	Thyroid	☐	☐	Other _____