Vision Source of Mandeville

Patient Demographic and Medical Information

Patient's Last Name: _____ First: _____ MI: _____

DOB: _____ Gender: M F Marital Status: S M W D SS#: _____

Address: _____ City: _____ ST: ____ ZIP:_____

Telephone: Home-_____ Work-_____

Cell Phone-_____ Email: _____

Employer: _____ Occupation: _____

Who do we contact in case of an emergency? _____ Phone: _____

Additional Information

Name of patient's VISION benefit plan: _____

Name of patient's MAJOR MEDICAL carrier: _____

Name of patient's primary physician: _____ Phone: _____

Would you like to receive a copy of our HIPAA Privacy Notice? Yes or No Initials: _____ Date: _____

Insurance Information

Primary Member's Last Name: _____First: _____

DOB: _____ Gender: M F Marital Status: S M W D SS#: _____

Address: _____City: _____ ST: _____ ZIP:_____

Telephone: Home-_____ Cell-_____

Member's Relationship to patient: _____

RELEASE OF INFORMATION, GUARANTEE OF PAYMENT, and SIGNATURE FOR FILE: I authorize any holder of medical or other information about me to release to the Social Security Administration, Centers for Medicare & Medicaid services, its intermediaries or my medical insurance carrier any information needed for a medical claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to my physician. Insurance companies do not guarantee payment. In the event the services I accepted and received are not covered by my insurance, I understand that I am responsible for all the charges and I further agree to pay any and all costs associated with collecting these fees, including but not limited to reasonable attorney and collection fees, court costs, and costs of appeal.

PRINTED NAME: _____ DATE: _____

SIGNATURE: _____

*********** PLEASE COMPLETE MEDICAL AND OCULAR HISTORY *ON THE BACK OF THIS PAGE***********

Date of last exam:

Currently wear glasses? Yes No

Currently wear contacts? Yes No

Reason for today's visit:

Have you or an immediate family member experienced or were treated for any of the following? Circle all that apply.

Cataracts	Yes	No	Family
Crossed Eye	Yes	No	Family
Glaucoma	Yes	No	Family
LASIK or RK	Yes	No	Family
Lazy Eye	Yes	No	Family
Macular Degeneration	Yes	No	Family
Retinal Detachment	Yes	No	Family

Are you currently experiencing, or have experienced, any of the following? Check all that apply.

- ○ **Blurry Vision** Near Distance
- ○ **Burning**
- ○ **Discharge**
- ○ **Double Vision**
- ○ **Dryness**
- ○ **Excess Tearing/Watering**
- ○ **Eye Infection**
- ○ **Eye Pain or Soreness**
- ○ **Floaters or Spots**
- ○ **Halos**
- ○ **Headaches**
- ○ **Itching**
- ○ **Light Flashes**
- ○ **Light Sensitivity**
- ○ **Redness**
- ○ **Sandy or Gritty Feeling**

Pharmacy Name and Number:

Have you or an immediate family member experienced or were treated for any of the following? Circle all that apply.

AIDS/HIV		Yes	No	Family
Allergies		Yes	No	Family
Arthritis		Yes	No	Family
Asthma		Yes	No	Family
Blood/Lymph Disorder		Yes	No	Family
Cancer		Yes	No	Family
Diabetes	TYPE 1 or 2	Yes	No	Family
	Insulin Dependent	Yes	No	
Ears, Nose, Throat Conditions		Yes	No	Family
Gastrointestinal Conditions		Yes	No	Family
Heart Disease		Yes	No	Family
High Blood Pressure		Yes	No	Family
High Cholesterol		Yes	No	Family
Kidney Disease		Yes	No	Family
Lupus		Yes	No	Family
Neurological Conditions		Yes	No	Family
Psychiatric Disorder		Yes	No	Family
Seizures		Yes	No	Family
Skin Conditions		Yes	No	Family
Stroke		Yes	No	Family
Thyroid Dysfunction		Yes	No	Family

Current Medications: (prescription and over the counter with dosage)
-- You may provide a list that we can copy --

Medication Drug Allergies:

Are you pregnant or nursing?

Do you smoke? Y N How often/many?

Have you ever smoked?