Driver's Lic # _____ Recall Code _____

State _____ Please Print First Visit _____

Patient's Name _____ Date ___ / ___ / ___

If Married, Spouse' Name _____ (Last) (First) If Child, Parent's Name _____

Address _____ City _____ State _____ Zip Code _____

Phone (____) _____ Social Security # _____ /_____/_____ Age _____ DOB _____

Place of Employment/School _____ Business Phone (____) _____

Cell Phone (____) _____ Email _____

Occupation _____ Medicare # _____ Medical Insurance: ☐ Yes ☐ No

Other Group Health Plan and Ins # (If Any) _____ Vision Care Plan (If Any) _____

Does Your Work Require Special Vision Care? If So, Please Explain

Title: Mr. Mrs. Miss Ms. Other _____ ☐ Male ☐ Female

List ACTIVITIES/HOBBIES you participate in that may require special vision care: _____

Date of Last Exam: _____ Are you wearing contact lenses ☐ Yes ☐ No

Are you interested in wearing contacts lenses ☐ Yes ☐ No

Reason for Today's Visit: _____

How Were you Referred to our Office: _____

Any Special Eye or Vision Problem: _____

Method of Payment: ☐ Cash ☐ Check ☐ C/C ☐ Other _____

MEDICAL HISTORY

Medical Dr. _____ Last Visit ___ / ___ / ___ Phone (____) _____

Does anyone in your family have medical problems? Yes ☐ No ☐

Explain _____

HAVE YOU EVER BEEN TREATED FOR ANY OF THE FOLLOWING?

Review of Systems	Yes	No	In-Family
Allergies			
High Blood Pressure			
Heart Disease			
Diabetes			
Gastrointestinal			
Cancer			
Endocrine Thyroid			
Ear – Nose – Throat			
Headaches			
Urinary			
Blood Lymph Nodes			
Respiratory			

Are you taking any medications? _____

_____

_____

_____

Allergies: Yes ☐ No ☐ _____

List: _____

OCCULAR HISTORY

Blurred Vision	Y / N	Eyelid Problem	Y / N
Double Vision	Y / N	Glaucoma	Y / N
Tired when Reading	Y / N	Tearing	Y / N
Spots	Y / N	Surgery	Y / N
Cataracts	Y / N	Trauma	Y / N

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS OR OTHER INSURANCE BE MADE EITHER TO ME OR ON MY BEHALF TO EYE CLINIC OF VERO FOR ANY SERVICES FURNISHED ME BY THE CLINIC. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME, TO RELEASE TO THE HEALTHCARE FINANCING ADMINISTRATION AND ITS AGENTS, ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES.

LIFETIME PATIENT SIGNATURE: _____ DATE: _____