CONFIDENTIAL PATIENT INFORMATION

PATIENT INFORMATION

First Name_____ **Contact Preference:** __**Home** __**Cell** __**Work**___

Last Name_____**Middle**_____ **Home Phone:**_____

Preferred Name: _____ **Work Phone:**_____

Address_____ **Cell Phone:**_____

City _____ **e-mail:**_____

State_____**Zip**_____ **Marital Status**_____

Date of Birth_____ **Right Handed**_____ **Left Handed**_____

Social Security Number_____ **Employer**_____

Gender: M F Language:_____ **Occupation**_____

Race: ___Caucasian ___Native American __Hispanic
___Pacific Islander ___African American __Other

INSURANCE AND FINANCIAL INFORMATION

Vision Insurance _____ **Medical Insurance** _____

Primary Insurance Holder ☐ **Self** ☐ **Other: Complete the section below if you are not primary insurance holder:**

_____

Date of Birth Insured_____ **SSN of Insured**_____

Person responsible for account (if not patient)_____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

The law requires that Envision Eye Care make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

Please Mark One:

- ☐ **I have read or had explained to me Envision Eye Care's Notice of Privacy Practice and agree to continue my care with Envision Eye Care under said terms.**
- ☐ **I was given to opportunity to read Envision Eye Care's Notice of Privacy Practices and declined but wish to continue my care with Envision Eye Care under the terms of Envision Eye Care's privacy policies.**
- ☐ **I have read or had explained to me Envision Eye Care's Notice of Privacy Practice and do not wish to continue my care with Envision Eye Care under said terms.**
- ☐ **The Notice of Privacy Practice could not be read due to the emergent nature of the care or other reason described as**

  _____

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

_____ _____
Patient **Date**

If you are signing as a personal representative of the patient, please indicate your relationship

_____ _____
Representative **Relationship to Patient**

PATIENT MEDICAL HISTORY

GENERAL HISTORY

Date of last eye exam_____ Previous eye doctor_____

Medical doctor_____ Hours spent on computer per day_____

YOUR MEDICAL HISTORY

Circle any eye conditions you have been diagnosed with: Cataract Macular Degeneration Glaucoma Diabetes Diabetic Retinopathy Dry Eye Iritis/Uveitis Retinal degeneration/detachment
Other: _____

Circle any eye conditions a family member has been diagnosed with:
Include only Grandparent/Parent/Sibling/Aunts/Uncles and Children

Cataract Macular Degeneration Glaucoma Diabetes Diabetic Retinopathy Dry Eye Iritis/Uveitis

Retinal Degeneration/Detachment Other: _____

Current Vision Correction (Please Circle): Glasses Contacts Surgical Correction None

List any medications you take:
You may omit this item if you brought a list with you.

_____
_____

List any allergies to medications:

_____

List all major injuries, surgeries, and/or hospital stays -

_____
_____

Have you been diagnosed with conditions of any of the following systems: Please list
Yes/No Cardiovascular_____ Yes/No Endocrine(diabetes/thyroid)_____
Yes/No Digestive_____ Yes/No Reproductive_____
Yes/No Blood/Lymphatic_____ Yes/No Immunologic_____
Yes/No Skin_____ Yes/No Muscles/Bones_____
Yes/No Neurologic_____ Yes/No Psychiatric_____
Yes/No Lungs/Breathing_____

Circle any conditions a family member has been diagnosed with: Cancer Diabetes Hypertension
Include only Grandparent/Parent/Sibling/Aunts/ Uncles and Children

YOUR SOCIAL HISTORY

Smoking Status:___Non-Smoker ___Former Smoker__Current Smoker
Do you drink Alcohol? ____Yes____No
Hobbies_____

EMERGENCY CONTACT

Name_____ Relationship_____ Phone_____