

WELCOME!

PATIENT INFORMATION

Patient's Last name:	First:	MI:	Social Security:	
E-mail:			(ONLY if using INSURANCE)	
Home Phone:	Cell Phone:	Other:	Birthdate: / /	Age:
Address:				
City:	State:	ZIP Code:		
Occupation, Hobby:	Employer:	Computer Use hours:		
Chose office because/Referred to by (please check one box):		<input type="checkbox"/> Dr.(Primary)	<input type="checkbox"/> School	<input type="checkbox"/> Insurance Plan
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Internet/Website, Facebook	<input type="checkbox"/> Local Magazine <input type="checkbox"/> WALK - IN
Other family members/friends seen here:				

OCULAR & MEDICAL HISTORY

Last Eye Exam:	Reason for today's visit: Exam___ Glasses___ Contact Lenses___ Medical Visit_____	Last Medical Exam:
Do you wear Contact Lenses? <input type="checkbox"/> Yes / <input type="checkbox"/> No	If so, what Brand: Do YOU sleep with contacts? <input type="checkbox"/> YES / <input type="checkbox"/> No	<u>DISPOSE CL'S?</u> DAILY / 2 WEEKS MONTHLY / RIGID / _____
What solution do you use to CLEAN Contacts? OptiFree, BioTrue, Complete, Revitalens, Clear Care	Have YOU ever had any EYE INJURY, SURGERY OR INFECTION? _____	Are YOU interested in LASIK Surgery? <input type="checkbox"/> YES / <input type="checkbox"/> No
Do YOU have any of the following?	<input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Diabetes <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Thyroid <input type="checkbox"/> Heart Disease / Stroke <input type="checkbox"/> Cancer <input type="checkbox"/> Other _____	<input type="checkbox"/> Depression / Anxiety <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia/ Arthritis /Hearing Loss
Do YOU or any of your family members have?	<input type="checkbox"/> Glaucoma <input type="checkbox"/> Retinal Disease <input type="checkbox"/> Cataract <input type="checkbox"/> Macular Degeneration: (Self or Family) _____	<input type="checkbox"/> Amblyopia (Lazy Eye) <input type="checkbox"/> Strabismus (Eye turn) <input type="checkbox"/> Blindness
What are YOUR Visual /Ocular Complaints?		
<input type="checkbox"/> Blur @ Distance / Near	<input type="checkbox"/> Loss of Vision	<input type="checkbox"/> Ocular Pain
<input type="checkbox"/> Floaters / Flashes	<input type="checkbox"/> Light Sensitivity	<input type="checkbox"/> Headaches / Migraines
<input type="checkbox"/> Burning <input type="checkbox"/> Tearing	<input type="checkbox"/> Itching <input type="checkbox"/> Redness	<input type="checkbox"/> Stye
Other: _____		
What MEDICATIONS do you take, if any?		
Do YOU have any ALLERGIES? _____		
(Women Only) Are you PREGNANT/NURSING? <input type="checkbox"/> Yes / <input type="checkbox"/> No		

DILATION INFORMATION

To provide the most complete evaluation of your eyes, it is necessary to administer drops to dilate your pupils. The dilation will temporarily affect your vision for 3-4 hours. We will provide sunshades for driving for maximum comfort:

YES, DILATE MY PUPILS TODAY RESCHEDULE DILATION FOR ANOTHER DAY NO, I REFUSE DILATION TODAY

INSURANCE INFORMATION

(PLEASE GIVE PHOTO ID & INSURANCE CARD TO RECEPTIONIST)

VISION INSURANCE: ID:	MEDICAL INSURANCE: ID:
MAIN SUBSCRIBER NAME, DATE OF BIRTH:	MAIN SUBSCRIBER NAME, DATE OF BIRTH:

I authorize my insurance benefit to be paid directly to Pro Vision Eye Care Center (Dr. Jesus Cuevas / Dr. Anastasia Jobson-Cuevas). **I understand that I am financially responsible for any balance that is not covered by my insurance.** An Authorization does not guarantee payment.

I also authorize Pro Vision Eye Care Center or my insurance company to release any information required to process my claims. We have "Notice of Privacy Practices" that describes the use and disclosure of your personal medical information in detail as per federal law. (copies at front desk)

PATIENT /GUARDIAN SIGNATURE: _____

DATE: _____

