



Welcome To Our Office

Date _____

PATIENT INFORMATION

Name _____ Birthdate _____ Sex M / F

Address _____ SocSec# _____

City, State, Zip _____

Home _____ Work _____ Cell _____

Email _____ Where do you prefer to receive calls? Home Work Cell

Occupation _____ Employer _____

Name of Spouse / Parent / Guardian _____

Contact in case of emergency Name _____ Phone _____

Whom may we thank for referring you? _____

Who is responsible for the payment on this account? Patient Spouse Parent Guardian

If the information for the responsible party is different from what is listed above, please complete the following:

Name _____

Address _____

City, State, Zip _____ Phone _____

May we contact the responsible party to confirm payment arrangement? Yes No

Primary Insurance Information

Subscriber Name _____

Patient's relationship to subscriber: Self Spouse Child Other

Birthdate _____ Employer _____

Insurance _____

ID# _____ Grp# _____

Secondary Insurance Information

Subscriber Name _____

Patient's relationship to subscriber: Self Spouse Child Other

Birthdate _____ Employer _____

Insurance _____

ID# _____ Grp# _____

Bellevue Vision Clinic will make a good faith attempt to verify insurance benefits prior to your appointment but does not guarantee insurance coverage for services.

Acknowledgement of Receipt of Privacy Policies

I acknowledge that I have received a copy of the Notice of Privacy Practices for this office.

Signature of Patient, Parent or Guardian: _____

Name _____ Date _____

Vision and General Health History

Date of last eye exam _____

Are you having difficulties with your vision? Yes No

If yes, please explain _____

Do you wear glasses? Yes No How old are your current glasses? _____

When do you wear glasses? All the time Reading / Near work Distance only
Computer work Work safety Other _____

Do you wear contacts? Yes No

If yes, type / brand _____ Hours per day worn? _____

How often do you replace them? _____ Solution used? _____

Describe any problems you are having with your contacts: _____

Please circle all that currently apply to your eyes: Blurry Burning Dry Itchy Red
Floaters Discharge Pain Eyestrain Light Sensitivity Headaches
Other _____

Have you ever had any of the following:

Eye surgery	No	Yes	_____
Eye disease	No	Yes	_____
Eye injury	No	Yes	_____
Floaters	No	Yes	_____
Loss of Vision	No	Yes	_____
Lazy Eye	No	Yes	_____
Droopy Eyelid	No	Yes	_____
Protruding Eyes	No	Yes	_____

Are you being treated for any medical conditions? (e.g. high blood pressure, high cholesterol, kidney disease, liver disease, arthritis, diabetes, thyroid disease, lupus) No Yes

List _____

List medications you are currently taking including over the counter meds and eye drops _____

Do you have any allergies to medications? Yes No List _____

Have you been hospitalized or had surgery within the past 5 years? Yes No

Please list _____

Name of Primary care Physician or Pediatrician _____

Review of Systems

Do you currently have any of the following problems? If yes, please explain:

- Chronic fever, unexpected weight gain / loss, fatigue No Yes _____
- Ear / nose / throat problems (e.g. hearing loss, sinus problems, sore throat) No Yes _____
- Heart problems (e.g. chest pain, irregular heartbeat) No Yes _____
- Respiratory problems (e.g. shortness of breath, cough, asthma) No Yes _____
- Gastrointestinal problems (e.g. heartburn, abdominal pain, diarrhea) No Yes _____
- Urinary problems (e.g. pain, blood in urine, prostate problems) No Yes _____
- Skin problems (e.g. rashes, eczema, excessive dryness) No Yes _____
- Musculoskeletal problems (e.g. muscle aches, joint pain, back pain) No Yes _____
- Neurological problems (e.g. numbness, weakness, Parkinson's, MS, etc.) No Yes _____
- Psychiatric problems (e.g. depression, anxiety) No Yes _____
- Other _____

Family History

Does anyone in your family (blood relatives) have a history of the following? Please list relationship.

- Diabetes No Yes _____
- Macular degeneration No Yes _____
- Cataracts No Yes _____
- Lazy eye No Yes _____
- Glaucoma No Yes _____
- Retinal disease or detachment No Yes _____
- Poor color vision No Yes _____
- Other health problems _____

Social History

Do you smoke? Yes No **Females**, are you pregnant or nursing? Yes No

How many hours of computer work daily? _____

Patient signature (or parent if a minor) _____ Date _____

FOR OFFICE USE ONLY

Date Reviewed	Changes
_____	No Changes _____
_____	No Changes _____
_____	No Changes _____
_____	No Changes _____