Patient Intake Form & HIPPA Release

Patient Name: _____ Date: _____

Address: _____ City: _____ Zip: _____

Phone: _____ E-Mail: _____

Date of Birth: _____ Social Security Number: _____

Primary Care Physician: _____ Phone Number: _____

Occupation: _____ Employer: _____

Primary Medical Insurance: _____ ID #: _____

Primary Policy Holder: _____ Relationship: _____ DOB: _____

Secondary Insurance: _____ ID #: _____

Vision Insurance: _____ ID#: _____

I agree to be financially responsible for any balance not paid by my insurance plan. I understand that balances must be paid in full before next appointment. I agree to be financially responsible for any balance not paid by my insurance plan. I understand that balances must be paid in full before next appointment. This also allows Vision for Life to release to any physician, insurance company, or official government agency; all information regarding the medical history and/or treatment rendered to me.

_____ _____

Patients or responsible party signature Date

Medical History

Allergies: _____

Medications:

_____

_____

List all surgeries, injuries, hospitalizations:

_____

Have you or your family had: Crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infection or eye injury? _____

Are you pregnant or nursing? Yes No

Do you wear glasses? Yes No If Yes, how old are your current lenses? _____

Do you wear contacts? Yes No If Yes, how old are your current lenses? _____

Are you interested in refractive surgery/ LASIK? Yes No

Social History

Do you drive? Yes No If Yes, do you have any difficulty? _____

Have you ever been a tobacco user? Yes No If Yes, type, amount, how long: _____

Do you drink Alcohol? Yes No If Yes, type, amount, how long: _____

Do you use any illegal drugs/narcotics? Yes No If Yes, type, amount, how long: _____

Have you ever been exposed to or diagnosed with: Gonorrhea Hepatitis HIV Syphilis

_____ _____

Doctor Signature Date

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