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 #:______________

Secondary Policy Holder: __________________Relationship:________DOB:________

Vision Insurance: ____________________________ ID#:______________

Vision Policy Holder: ____________________Relationship:________DOB:________

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 Valley Stream Optometric Services 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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Review of Systems

Have you had any problems with the following areas?

System	Yes	No
Constitutional		
Fever Weight Loss/ Gain	Yes	No
Neurological		
Headaches	Yes	No
Migraines	Yes	No
Seizures	Yes	No
Eyes		
Loss of Vision	Yes	No
Blurred Vision	Yes	No
Distorted Vision/ Halos	Yes	No
Loss of Side Vision	Yes	No
Double Vision	Yes	No
Dryness	Yes	No
Mucous Discharge	Yes	No
Redness	Yes	No
Sandy or Gritty Feeling	Yes	No
Itching	Yes	No
Burning	Yes	No
Foreign Body Sensation	Yes	No
Excess Tearing/ Watering	Yes	No
Glare/ Light Sensitive	Yes	No
Eye Pain or Soreness	Yes	No
Chronic Infection of Eye or Lid	Yes	No
Sties or Chalazion	Yes	No
Flashes/ Floaters in Vision	Yes	No
Tired Eyes	Yes	No
Endocrine		
Thyroid/Other Glands	Yes	No
Psychiatric	Yes	No

	Yes	No
Ears, Nose Mouth, Throat		
Allergies/ Hay Fever	Yes	No
Sinus Congestion	Yes	No
Runny Nose	Yes	No
Post-Nasal Drip	Yes	No
Chronic Cough	Yes	No
Dry Throat/Mouth	Yes	No
Respiratory		
Asthma	Yes	No
Chronic Bronchitis	Yes	No
Emphysema	Yes	No
Vascular/ Cardiovascular		
Diabetes	Yes	No
Heart Pain	Yes	No
High Blood Pressure	Yes	No
Vascular Disease	Yes	No
Gastrointestinal		
Diarrhea	Yes	No
Constipation	Yes	No
Genitourinary		
Genitals/Kidney/Bladder	Yes	No
Bones/Joints/Muscles		
Rheumatoid Arthritis	Yes	No
Muscle Pain	Yes	No
Joint Pan	Yes	No
Lymphatic/Hematologic		
Anemia	Yes	No
Bleeding Problems	Yes	No
Allergic/Immunologic		
Immunodeficiency	Yes	No
Integumentary (Skin)	Yes	No

Family History

Please note any family history (parents, grandparents, siblings, and children)

Disease/Condition	Yes	No	Relationship to You
Blindness	Yes	No	
Cataract	Yes	No	
Crossed Eyes	Yes	No	
Glaucoma	Yes	No	
Macular Degeneration	Yes	No	
Retinal Detachment/Disease	Yes	No	
Arthritis	Yes	No	
Cancer	Yes	No	
Diabetes	Yes	No	
Heart Disease	Yes	No	
High Blood Pressure	Yes	No	
Kidney Disease	Yes	No	
Thyroid Disease/Lupus	Yes	No	

Doctor Signature

Date