Patient Entry Form

Please make all corrections below

NAME:
Date of Birth:

ADDRESS:

HOME PHONE:
WORK PHONE:
CELL PHONE:

E-MAIL ADDRESS:

Check off all that apply:

Self	Family	
□	□	Macular Degeneration
□	□	Glaucoma
□	□	Cataracts
□	□	Blindness
□	□	Retinal Degeneration
□	□	Crossed/ Lazy eyes
□	□	Color Blindness
□	□	High Blood Pressure
□	□	Diabetes
□	□	Heart Problems
□	□	Cholesterol
□	□	Stroke
□	□	Cancer
□	□	Arthritis
□	□	Thyroid Condition
□	□	HIV/ Hepatitis
□	□	Asthma/ Allergies
□	□	Neuromuscular
□	□	Autoimmune: _____
□	□	Other: _____
□		Pregnant or Nursing

What brought you in:

- □ Blurry distance vision
- □ Blurry near vision
- □ Poor night vision
- □ Eye strain
- □ Glare/ Reflections
- □ Sandy/ Dry eyes
- □ Watering
- □ Discharge
- □ Pain in the eye
- □ Burning eyes
- □ Red eyes
- □ Itchy eyes
- □ Discomfort in sunlight
- □ Floaters or spots in vision
- □ Flashes of light
- □ Double vision
- □ Headaches
- □ Eye injury: _____
- □ History of wearing an eye patch
- □ History of eye surgery
- □ Dental Abscess
- □ Other: _____

Are you interested in:

- □ New spectacles
- □ Contact Lenses
- □ Colored contact lens
- □ Light weight glasses
- □ Anti-Reflective lens
- □ Sunglasses
- □ Clip-ons
- □ Safety glasses
- □ Lasik
- □ Dry Eye therapy

How you were referred to us:

- □ Family doctor
- □ Insurance Company
- □ Yellow pages
- □ Another patient: _____
- □ Other: _____

Social history:

- □ Tobacco use
- □ Alcohol use
- □ Drug use

Last eye exam: _____
Medications: _____
_____
Occupation: _____
Employer: _____
Family Doctor: _____
Allergies: _____

Acknowledgement of Receipt of this Notice

This Practice is concerned about the privacy of our patient's health care information. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your healthcare services will in no way be conditioned upon your signed acknowledgement. If you decline to provide a signed acknowledgement, we will continue to provide your treatment and will use and disclose your protected health information for treatment, payment, and health care operations when necessary.
I acknowledge that I have received the Notice of Privacy Practices for Vision Plus.

Signature of patient/authorized representative_____ Date_____