Vision Plus

Patient Information

Please make all applicable corrections below.

NAME: **DATE OF BIRTH:**
ADDRESS: **HOME PHONE:**
                                                                                                      WORK PHONE:
                                                                                                      CELL PHONE:
                                                                                                      E-MAIL ADDRESS:

Service Card/BC Care Card:
Insurance Company:
Group/Policy Number: **Member ID Number:**

Check off all that apply:		What brought you in:	Are you interested in:
Self	**Family**		
□	□ Macular degeneration	□ Blurry distance vision	□ New spectacles
□	□ Glaucoma	□ Blurry near vision	□ Contact lenses
□	□ Cataracts	□ Poor night vision	□ Colored contact lens
□	□ Blindness	□ Eye strain	□ Light weight glasses
□	□ Retinal degeneration	□ Glare / Reflections	□ Anti-reflective lens
□	□ Crossed / Lazy eyes	□ Sandy / Dry eyes	□ Sunglasses
□	□ Color blindness	□ Watering	□ Clip-ons
□	□ High blood pressure	□ Discharge	□ Safety glasses
□	□ Diabetes	□ Pain in the eye	□ Lasik
□	□ Heart problems	□ Burning eyes	□ Dry eye therapy
□	□ Cholesterol	□ Red eyes	
□	□ Stroke	□ Itchy eyes	**How you were referred to us:**
□	□ Cancer	□ Discomfort in sunlight	□ Family doctor
□	□ Arthritis	□ Floaters or spots in vision	□ Insurance Company
□	□ Thyroid Condition	□ Flashes of light	□ Google / Web Search
□	□ HIV/ Hepatitis	□ Double vision	□ Another patient: _____
□	□ Asthma/ Allergies	□ Headaches	□ Other: _____
□	□ Neuromuscular	□ Eye injury: _____	
□	□ Autoimmune: _____	□ History of eye patch wear	**Social history:**
□	□ Other: _____	□ History of eye surgery	□ Tobacco use
□	□ Pregnant or Nursing	□ Dental Abscess	□ Alcohol use
		□ Other:	□ Drug use

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

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:**