VisionCare ASSOCIATES | Blue Sky VISION | Partner

Lead the Way. Improve Sight. Change Lives.

PATIENT INFORMATION

Patient Last Name: _____ First: _____ Middle: _____

Marital Status (circle one) Single / Mar / Div / Sep / Wid /Partnered

Is this your legal name?: Y / N If no, what is your Legal Name?: _____

Former Last Name: _____

DOB: _____ Age: _____ Sex: □ M □ F Social Security No.: _____

Street Address: _____ P.O. Box: _____ City: _____ State: _____

Zip Code: _____ Email Address: _____

Cell Phone: _____ Preferred □ Home Phone: _____ Preferred □ Day Phone: _____ Preferred □

Emergency Contact Name:_____ Emergency Contact Phone:_____

Employment Status: □ FT □ PT □ Self Employed □ FT Student □ Retired □Not Employed □Other _____

Occupation: _____ Employer: _____

Medical Insurance: _____ Subscriber Name:_____
Subscriber DOB_____

Vision Insurance: _____ Subscriber Name:_____
Subscriber DOB_____

Additional Insurance: _____ Subscriber Name:_____
Subscriber DOB_____

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HIPAA ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY POLICIES

I acknowledge that I received a copy of the Notice of Privacy Practices for this office. Pursuant to the information and rights presented in the Notice above you may write your request to restrict uses and/or disclosures of your protected health information on the back of this page.

I authorize VisionCare Associates to share my health and prescription information with the following individual(s):

1. _____ *2.* _____

_____ _____
Patient/Guardian signature *Date*

I authorize the release for medical records to insurance carriers for payments of medical services rendered to my dependant or myself. ***I understand I am responsible for any amount not covered by my insurance when services are rendered.***

_____ _____
Patient/Guardian signature *Date*

PLEASE COMPLETE SIDE 2

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MEDICAL INFORMATION

Primary Care Physician Name & Location:_____

Diabetes: Y / N Type: _____ Date of Diagnosis: _____ Avg Sugar Level: _____ Med Dosage: _____

Allergies to Medications: _____

Health Conditions- *please check all that apply:*

___ High Blood Pressure	___ Arthritis	___ Kidney Disease	___ Stroke
___ Heart Disease	___ Depression	___ Prostate	___ Asthma
___ Sleep Apnea	___ Anxiety	___ Blood Disorder	___ Emphysema
___ Hearing Disorder	___ Thyroid Disorder	___ Multiple Sclerosis	___Hormone Replacement
___ Sinus	___ Cancer	___ Migraines	___ Pregnant
___ Skin Disorder	___ Ulcers/reflux	___ Seizures	___High Cholesterol

Other_____

Previous Surgeries: _____

Eye Injuries: _____

Cigarette Use: _____ **Alcohol Use:** _____ **Other substances:** _____

Patient Ocular History – *please check all that apply:*

____Glaucoma ____Lazy Eye ____Cataracts _____Macular Degeneration

____Retinal problems Other_____

Family History –*please check all that apply:*

____High Blood Pressure ____Diabetes ____Glaucoma _____Macular Degeneration

Other_____

CURRENT MEDICATIONS/SUPPLEMENTS

1. _____ Reason: _____
2. _____ Reason: _____
3. _____ Reason: _____
4. _____ Reason: _____
5. _____ Reason: _____

I understand it is my responsibility to inform VisionCare Associates of any changes to the above.

_____ _____

Patient/Guardian signature *Date*