vision without limits

Advanced eye care that clearly fits your lifestyle

Patient Information

Date _____

Patient Name (Last) _____

(First) _____ (Middle) _____

Address _____

City _____

State _____ Zip _____

E-Mail _____

Sex M/F Birthdate _____

SS# _____

Married Widowed Single Minor

Separated Divorced Partnered for _____ years

Occupation _____

Patient Employer/School _____

Primary Phone _____

Cell Phone _____

Work Phone _____

In case of Emergency Contact (#) _____

(Name) _____

Spouse's Name _____

Birthdate _____ SS# _____

Spouse's Employer/Phone # _____

Insurance Information

Vision Insurance Company _____

ID # _____

Assignment and Release

I certify that I, and/or my dependent(s), have Insurance coverage and assign directly to Vision Without Limits, LLC all insurance benefits, if any, otherwise payable to me for services rendered.

I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named entity may use my health care information and may disclose such information to the above-named Insurance Company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

(Signature of Patient, Parent, Guardian or Personal Representative)

(Please print name of Patient, Parent, Guardian or Personal Representative)

Date Relationship to Patient

Whom may we thank for referring you?

Eye Health History

Date of Last Eye Exam _____ Do you wear eyeglasses? Yes/No Name of Eye Doctor _____

When do you wear your eyeglasses? All the time Reading Occasionally Driving TV Other:

Do you wear contact lenses? Yes/No Type/Brand _____ Hours/Day _____

Describe any problems you have with your contact lenses _____

Please circle Yes or No to indicate if you have any of the following:

Bloodshot Eyes	Yes/No	**Crossed Eyes**	Yes/No	**Eye Injury**	Yes/No	**Itching Eyes**	Yes/No	**Seeing Halos**	Yes/No
Blurred Vision-Distance	Yes/No	**Discharge from Eyes**	Yes/No	**Eye Strain**	Yes/No	**Light Sensitive**	Yes/No	**Seeing Flashes**	Yes/No
Blurred Vision-Near	Yes/No	**Dizzy Spells**	Yes/No	**Fainting or Blackouts**	Yes/No	**Loss of Vision**	Yes/No	**Temporary Loss of Vision**	Yes/No
Burning Eyes	Yes/No	**Double Vision**	Yes/No	**Floaters or Spots**	Yes/No	**Migraine Headaches**	Yes/No	**Twitching Eyelid**	Yes/No
Cataracts	Yes/No	**Dry Eyes**	Yes/No	**Glaucoma**	Yes/No	**Night Vision, Poor**	Yes/No	**Vision Poor**	Yes/No
Color Vision, Poor	Yes/No	**Eye Infection**	Yes/No	**Headaches**	Yes/No	**Red Eyes**	Yes/No	**Watering Eyes**	Yes/No

Our Policy for payment expectations and appointments for children under 16 years of age is the following:

Children under 16 need to be accompanied by a parent or guardian. Payment in full or Prior payment arrangements are expected at time of service.

Children under 16 should not be left unattended during the visit. Parents are invited to be present during the children's exam.

Eyeglass and contact lens orders will not be placed until we have the express permission of the parent or guardian.

Thank you for your cooperation.

Please Flip Over --->

Health History

Physician's Name _____ Physician's Phone # _____

Please mark **Yes** or **No** if you or a blood relative have any of the following problems.

	Yourself	Family		Yourself	Family
AIDS/HIV	Yes/No	Yes/No	Hepatitis	Yes/No	Yes/No
Arthritis	Yes/No	Yes/No	High Blood Pressure	Yes/No	Yes/No
Artificial Joints	Yes/No	Yes/No	High Cholesterol	Yes/No	Yes/No
Asthma	Yes/No	Yes/No	Kidney Disease	Yes/No	Yes/No
Bleeding	Yes/No	Yes/No	Lazy Eye	Yes/No	Yes/No
Cancer	Yes/No	Yes/No	Lupus	Yes/No	Yes/No
Cataracts	Yes/No	Yes/No	Pacemaker	Yes/No	Yes/No
Chemical Dependency	Yes/No	Yes/No	Poor Color Vision	Yes/No	Yes/No
Diabetes	Yes/No	Yes/No	Retinal Disease	Yes/No	Yes/No
Drug Sensitivity	Yes/No	Yes/No	Rheumatic Fever	Yes/No	Yes/No
Emphysema	Yes/No	Yes/No	Shingles	Yes/No	Yes/No
Epilepsy	Yes/No	Yes/No	Skin Conditions	Yes/No	Yes/No
Eye Surgery	Yes/No	Yes/No	Stroke	Yes/No	Yes/No
Glaucoma	Yes/No	Yes/No	Thyroid Conditions	Yes/No	Yes/No
Hay Fever	Yes/No	Yes/No	Tuberculosis	Yes/No	Yes/No
Heart Condition	Yes/No	Yes/No	Turned Eye	Yes/No	Yes/No
Are you pregnant?	_____		Tobacco use	_____	
Number of children?			Alcohol use		

Medications

List any medications you take: (if you have a list, we can copy)

Allergies

List any allergies you have:

Pharmacy Name _____

Address/Phone # _____

Are you happy with your current eyeglasses? Yes_____ No_____

Do you own or wear more than one pair of eyeglasses? Yes_____ No_____

If "Yes", what do you use them for? _____

Do you participate in any sports or outside activities? Yes ____ No _____

Swimming Golfing Gardening Walking Tennis Running Hiking Fishing Boating

Gun Range Shooting Other: _____

What are your hobbies?

Sewing Knitting Gaming Painting Embroidery

Reading Reading Music Drawing Dancing Bingo

Gardening Woodworking Model Building Crossword Puzzles Other: _____

Do you frequently drive at night? Yes _____ No _____ **If "Yes", do you notice halos around lights?** Yes _____ No _____

Do you wear prescription sunglasses? Yes _____ No _____

How would you describe the lighting at your personal work area? _____

How many hours do you sleep at night? _____ **Do you have trouble concentrating?** Yes _____ No _____

How many hours a day do you use digital devices? _____

Are your eyelids looking a little droopy? _____

Do you suffer from excessive watering or dry eyes? _____

Are you interested in an eye drop that can help you read? _____

Do you have a family history of Macular Degeneration? _____

HIPPA acknowledgement (please sign below):

Our Privacy Practice is not to release any of your information without your written consent.

(A copy of Notice of Privacy Practices is available upon request.)

Date: **Signature:**

Please Flip Over --->