

	Pa	itient Informa	tion		12603	Insur	ance Infor	mation	11011
Date					Vision Insura	ance Company			
Patient Name (I	Last)				ID#				
(First) (Middle)					Assignment and Release				
Address					I certify that I, and/or my dependent(s),				
City						have Insuranc	e coverage a	nd assign directly	
State	¥		Zip	1	te	o Vision Without	Limits, LLC a	Il insurance benefits,	
E-Mail					ifa	any, otherwise pa	yable to me	for services rendere	d.
Sex	M/F	Birthdate			I und	lerstand that I am	financially re	esponsible for all cha	rges
SS#					whet	ther or not paid by	insurance.	I authorize the use of	f my
Married	Widowed	Single	Minor		sign	ature on all insur	ance submis	sions. The above-nan	ned
Separated	Divorced	Partnered for		years		entity may use my	health care	information and may	,
Occupation					disc	close such informa	ation to the a	above-named Insuran	ice
Patient Employe	er/School		9		Co	mpany and their	agents for th	e purpose of obtainir	ng
Primary Phone					]	payment for serv	ices and det	ermining insurance	
Cell Phone					be	enefits or the ben	efits payable	for related services.	
Work Phone				10 10 10 10 10 10 10 10 10 10 10 10 10 1	Th	is consent will en	d when my c	urrent treatment pla	n
In case of Emerg	gency Contac	t (#)			is	completed or one	year from t	he date signed below	
(Name)					]				
Spouse's Name		,			(9	Signature of Patient, Pa	rent, Guardian (	or Personal Representative)	
Birthdate		SS#							
Spouse's Emplo	yer/Phone #				(Pleas	se print name of Patien	t, Parent, Guard	ian or Personal Representa	tive)
	8				Date		Relationship to	Patient	
Whom may w	e thank for	referring you?							
			1 7 7 2	Eye Healtl	h History		接換作品		4775
Date of Last Ey	e Exam		Do you wea	r eyeglasses?	Yes/No	Name of Eye D	octor		
When do you we	ear your eyeg	lasses?	All the time	Reading	Occasionally	Driving	TV	Other:	
Do you wear cor	ntact lenses?	Yes/No	Type/Brand			_ Hours/Day			
Describe any pro	oblems you h	ave with your con	tact lenses						
		Please	circle Yes or	No to indicate	if you have	any of the follow	ving:		
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	<b>Double Vision</b>	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 Po	olicy for payment	expectations	and appointment	ts for children	under 16 years o	f age is the f	ollowing:	
Children unde	r 16 need to l	be accompanied l	y a parent or	guardian. Payme	ent in full or P	rior payment arra	ingements a	re expected at time o	f service.
Chi	ldren under 1	L6 should not be I	eft unattende	d during the visit	. Parents are	invited to be pres	ent during t	he children's exam.	1
	Eyeglass a	nd contact lens or	ders will not b	oe placed until w	e have the ex	press permission	of the paren	t or guardian.	8 "
				hank you for yo					

Dhuaisia a la Nama		Healtl	n History			
Physician's Name			Physician's	Phone #		
Р	lease mark <b>Ye</b>	s or No if you or a blood r	elative have any of the fo	llowing prol	olems.	
	<b>Yourself</b>	<u>Family</u>		Yourself	<u>Family</u>	
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?	. 55, 5	. 33/110	Tobacco use	1 00/110	165/110	
Number of children?			Alcohol use		The state of the s	
	Medicatio		7 HEOMOT USE	Allergies		
Pharmacy Name						
Pharmacy Name Address/Phone #						
Address/Phone #	ır current eyegl	asses? Yes No				
Address/Phone # Are you happy with you		asses? Yes No ir of eyeglasses? Yes	No			
Address/Phone <u>#</u> Are you happy with you Do you own or wear mo	ore than one pa		No			***************************************
Address/Phone # Are you happy with you Do you own or wear mo f "Yes", what do you us	ore than one page se them for?					
Address/Phone # Are you happy with you Do you own or wear mo f "Yes", what do you us Do you participate in ar	ore than one page se them for?	ir of eyeglasses? Yes		Fishing	Boating	
Address/Phone #  Are you happy with you  Do you own or wear mo  f "Yes", what do you us  Do you participate in ar  wimming Golfing	ore than one pa se them for? ny sports or out	side activities? Yes N	0	Fishing	Boating	
Address/Phone #  Are you happy with you  Do you own or wear mo  f "Yes", what do you us  Do you participate in ar  wimming Golfing  Gun Range Shooting	ore than one pa se them for? ny sports or out Gardening Other:	side activities? Yes N	0	Fishing	Boating	
Address/Phone #  Are you happy with you  Do you own or wear mo  f "Yes", what do you us  Do you participate in ar  wimming Golfing  Gun Range Shooting  What are your hobbies	ore than one pa se them for? ny sports or out Gardening Other:	side activities? Yes N	0	Fishing		
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Address/Phone #  Are you happy with you be you own or wear mone of "Yes", what do you use you participate in an address of the your hobbies. The your hobbies of the your frequently drives you wear prescribilly downward you describe how many hours a day and you have a family him you have a family him you have a family him you would you have a family him you have a family him you have a family him you would you have a family him you have a family him you would you have a family him you have a family him you would you would you would you have a family him you would you	ore than one page them for?  Ity sports or out Gardening Other:  Itusic King at night? Yes on sunglasses?  It the lighting at at sleep at night do you use digit at little droopy sessive watering at eye drop that story of Macula	side activities? Yes N Walking Tennis  Gaming Drawing Model Building Yes No t your personal work area? ? tal devices? can help you read? ar Degeneration? HIPPA acknowledgem	Painting Painting Dancing Crossword Puzzles If "Yes", do you notice has  Do you have trouble con	Embroidery Bingo Other: alos around I	ights? Yes No 'es No	