A Visual Affair

PERSONAL INFORMATION Date of Birth ____/____/____ Age ____ Sex _____

Patient Name _____ Social Security _____

Address _____ City/State _____ Zip _____

Home Phone _____ Business Phone _____

Occupation _____ E-Mail _____

Family Physician _____ Telephone _____

How did you hear about our office? (If referred, who may we thank?) _____

Did you use any search engines such as Google or Yahoo to find us? If so, which one? _____

MEDICAL & VISION INSURANCE INFORMATION

Vision Insurance Company _____

Medical Insurance Company _____

Insurance Holder _____ Relationship to Patient _____

Insurance Holder Social Security _____ Insurance Holder Date of Birth ____/____/____

Policy No. _____ Plan No. _____ Group No. _____

HEALTH INFORMATION *(All major health insurers and Medicare now require us to obtain in depth patient medical history information. All information is kept strictly confidential.)*

Date of last complete eye exam _____ Date of last medical exam _____

List any medications currently on _____

List any medications you are allergic to _____

Do you suffer from any of the following:

Near vision blur	_____	Seeing spots/lines	_____	Headaches	_____
Distance vision blur	_____	Seeing flashes	_____	Eye Strain	_____
Double vision	_____	Seeing halos	_____	Dry Eyes	_____

Special vision requirements (Occupational/Driving/Hobbies/Sports) _____

Do you wear contact lenses? _____ Do you need to renew your contact lens Rx (requires an evaluation)? _____

Do you use tobacco products? _____ Do you drink alcohol? _____ Do you use illegal drugs? _____

Are you pregnant and/or nursing? _____

Do you or any family members have a history of: (please list relationship for family)

	Self	Family		Self	Family		Self	Family
High blood pressure	_____	_____	Neurological	_____	_____	Blood	_____	_____
Diabetes	_____	_____	Ear/Nose/Throat	_____	_____	Immune/Allergies	_____	_____
High cholesterol	_____	_____	Endocrine (Thyroid)	___	_____	Lazy (crossed) eye	_____	_____
Musculoskeletal	_____	_____	Respiratory	_____	_____	Glaucoma	_____	_____
Cardiovascular	_____	_____	Gastrointestinal	_____	_____	Macular degeneration	____	_____
Genitourinary	_____	_____	Mental	_____	_____	Retinal tears/disease	_____	_____
Cancer	_____	_____	Skin	_____	_____	Eye surgery	_____	_____

Other (explain) _____

In order to be medically and HIPAA compliant, your signature is required below. By signing the form, you also agree to:

1. Having received/reviewed copies of A Visual Affair's Notice of Privacy Practices and Return Policies.
2. Be responsible for payment of any services not paid by insurance in full.
3. Be responsible for all collection charges and legal expenses to collect payment.
4. Consider signature as 'on file' for billing insurance purposes.

Signature _____ Date: _____