provision EYECARE

Today's Date: _____

Patient Information

Patient Name: _____ Date of Birth: _____
First/MI/Last

Nickname: _____ SSN: _____

Address: _____ Employer/School: _____

City: _____ State: _____ Zip Code: _____ Occupation: _____

Primary Phone: (_____) _____ Responsible Party: _____

Additional Phone: (_____) _____ Referred By: _____

Email: _____ Preferred Language: _____

Preferred way of communication: ☐ Phone ☐ Email ☐ Text

Race:
- ☐ Decline to Specify
- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Black/African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White

Ethnicity:
- ☐ Decline to Specify
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Marital Status:
- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widowed

Gender:
- ☐ Male
- ☐ Female

Emergency Contact Information

Emergency Contact #1
Name: _____

Relationship: _____

Phone: (_____) _____

(Optional) Emergency Contact #2
Name: _____

Relationship: _____

Phone: (_____) _____

Additional Contact Information (As needed)

The following person (Spouse, Primary Care Physician, etc.) can have access to my information, medical and/or financial:

Name: _____ Phone: (_____)_____

Office: _____ Fax: (_____)_____

Insurance Information

Please have your Insurance Card/s available at time of appointment.

Do you have Vision Insurance? ☐ Yes ☐ No

Insurance Company: _____

ID# _____

Primary Member: _____

Primary DOB: _____

Do you have Health Insurance? ☐ Yes ☐ No

Insurance Company: _____

ID# _____

Primary Member: _____

Primary DOB: _____

Personal and Family Health History

Have you or any immediate family member (parent, grandparent, sibling) had any of the following conditions? **S** - self **F** - family

MEDICAL HISTORY	**S**	**F**		**S**	**F**	***VISION HISTORY***	**S**	**F**		**S**	**F**
Anxiety	□	□	GERD	□	□	Allergic Conjunctivitis	□	□	Pseudoexfoliation	□	□
Arthritis	□	□	Hearing Loss	□	□	Blepharitis	□	□	Retinal Tear- Right	□	□
Asthma	□	□	Hepatitis	□	□	Cataracts	□	□	Retinal Tear- Left	□	□
Irregular Heartbeat	□	□	Hypertension	□	□	Corneal Dystrophy	□	□	Lazy Eye	□	□
Bone Marrow Transplant	□	□	HIV/AIDS	□	□	Diabetic Retinopathy	□	□	PVD	□	□
BPH	□	□	High Cholesterol	□	□	Dry Eyes	□	□	Floaters	□	□
COPD	□	□	Hyperthyroidism	□	□	Glaucoma	□	□	Poor Color Vision	□	□
Coronary Disease	□	□	Hypothyroidism	□	□	Macular Degeneration	□	□	Optical Surgery	□	□
Depression	□	□	Radiation Treatment	□	□	Macular ERM	□	□	Other		
Diabetes type 1	□	□	Seizures	□	□	Narrow Angles	□	□			
Diabetes type 2	□	□	Stroke	□	□	Ocular Hypertension	□	□			
End Stage Renal Disease	□	□				Ophthalmic Migraine	□	□			

Please list any personal or family history of Cancer:

_____

_____

Please list all Medications:

_____

_____

Please list all Allergies:

_____

_____

List any Previous Surgeries (including Optical):

_____

_____

Do you smoke? ⬜ Yes ⬜ No If, yes, how much?_____

Do you drink alcohol? ⬜ Yes ⬜ No If, yes, how much? _____

Privacy Practices

In accordance with Provision Eyecare's respect for your privacy and for HIPAA regulations, we will only share your personal information with others directly related to your care. By signing below, you agree that Provision Eyecare, its staff, and its billing affiliates have: **1)** your full consent to treat as they see medically necessary, **2)** your permission to contact you at the phone numbers and email addresses provided, **3)** your assurance that you will assume full responsibility for any balances left unpaid by insurance. Exam balances are due on the date of the exam. By signing below, you also agree that you have read these privacy practices.

_____

Signature of Patient or Guardian Date