**Vision Source- Neal Lovett, OD, LLC\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Last) (First) (Middle)

Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Mailing address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status (please circle) married divorced single widowed

Name of last eye doctor\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last exam\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of your current pharmacy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Name of your medical doctor\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any medications you currently take (prescription, over-the-counter, eye drops) **Please include dosage and instructions** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any allergies you have. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List all **major illnesses** (glaucoma, diabetes, high blood pressure, heart attack, etc.) or injuries (trauma, include surgeries). \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you pregnant? Yes No Are you nursing? Yes No

Have you ever tried to wear contact lenses? Yes No Do you currently wear contact lenses? Yes No

Do you currently wear glasses? Yes No Do you chew tobacco? Yes No

Do you drink alcohol? Yes No If Yes: occasional 1/day 2-3/day 4+/day

Do you smoke? Yes No If Yes: occasional 1/2pk/day 1pk/day 1+pk/day

**Do you currently have any problems in the following areas?** (Please circle)

**Eyes** Glaucoma Yes No Mucous discharge Yes No

Cataracts Yes No Redness Yes No

Macular degeneration Yes No Sandy or gritty feeling Yes No

Itching Yes No Burning Yes No

Excessive tearing/watering Yes No Dry Eyes Yes No

Light sensitivity/glare Yes No Blurred vision Yes No

Double Vision Yes No Eye pain or soreness Yes No

Crossed eye/lazy eye Yes No Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**General/constitutional**

Fever Yes No Weight Loss Yes No Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you currently have problems in the following areas?** If “Yes”, please give explanation.

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Yes** | **No** | **Explanation of problem** |
| Ears, Nose, Throat (Sinus or ear infection, sore throat) |  |  |  |
| Cardiovascular (heart, blood vessels, etc.) |  |  |  |
| Respiratory (asthma, emphysema, etc.) |  |  |  |
| Gastrointestinal (stomach, intestines) |  |  |  |
| Urogenital (kidneys, bladder, etc.) |  |  |  |
| Muscles, Bones, Joints (arthritis, etc.) |  |  |  |
| Skin (acne, skin cancer, etc.) |  |  |  |
| Neurological (Multiple sclerosis, seizures, stroke) |  |  |  |
| Psychiatric (anxiety, depression, etc.) |  |  |  |
| Endocrine (diabetes, thyroid, etc.) |  |  |  |
| Blood disorders (high cholesterol, anemia, etc.) |  |  |  |
| Allergic/Immunologic (hay fever, lupus, etc.) |  |  |  |

**Family History**

Has anyone in your **family** ever had any of the following conditions? If Yes, who?

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | No | Relationship to Patient **(Father, Mother, Grandparent)** |
| Blindness |  |  |  |
| Glaucoma |  |  |  |
| Macular degeneration |  |  |  |
| Cancer |  |  |  |
| Diabetes |  |  |  |
| Heart Disease |  |  |  |
| High Blood Pressure |  |  |  |
| Thyroid Disease |  |  |  |
| Other |  |  |  |

We understand your time is valuable and do our best to make your visit efficient. Likewise, our time is valuable. If you are unable to keep an appointment, please provide 24 hours’ notice. **Failure to provide 24 hours’ notice of cancellation or failing to show up for an appointment without such notice will result in a charge of a $30 no-show fee which must be paid before you can be scheduled for any future appointments.** \_\_\_\_\_\_\_\_\_\_ Initial

There are two types of health insurance that will help pay for your eye care services and products. You may have both, and our practice accepts both. Vision care plans cover routine exams along with eyeglasses and contact lenses. Medical insurance plans are used if you have an eye health problem or system health problem that has ocular complications, such as diabetes. If you have both types of plans, it may be necessary for us to bill some services to one plan and other services to the other. We will use coordination of benefits to do this properly and to minimize your out-of-pocket expense.

By signing this form, I am authorizing this office to examine me, or my child. I authorize the release of any medical or other information necessary to process insurance claims. I authorize payment of benefits to be paid directly to this office. I understand that I am financially responsible for charges not paid by insurance. I acknowledge that all of the above information is correct, and I have read and understand the above policies. I acknowledge that I have been offered a copy of this office’s*Notice of Privacy Practices.*

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_