

Purcell Vision Source

PATIENT INFORMATION

Date _____	Patient Name _____	First Name	Middle Initial	Last Name	
Birthday _____	Social Security Number _____				
<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed
Race _____	Is English your primary language?	<input type="checkbox"/> Yes	<input type="checkbox"/> Other	_____	
Mailing Address _____	City _____	State _____	Zip _____		
E-mail _____					
Phone Numbers: Home _____	Cell _____				
Employer _____	Occupation _____				
In Case of Emergency Contact _____	Phone Number _____				
Who may we thank for referring you? _____					

INSURANCE

Vision Insurance _____	Medical Insurance _____	
Subscriber's Name _____	Relationship _____	
Subscriber's SSN _____	Birthday _____	Employer _____

Assignment of Benefits

I understand that my signature requests that payments from my insurance be made directly to the above named facility. I further authorize the release of any necessary information, including medical information, for the payment of this or any related claim.

_____	_____	_____
Signature of patient, parent, or guardian	Printed name of patient, parent, or guardian	Date

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGMENT

In the course of providing service to you, we create, receive, and store health information that identifies you. It is often necessary to use and disclose this information in order to treat you, to obtain payment for your services, and to conduct healthcare operation involving our office. The Notice of Privacy Practices you have been given describes these uses and disclosures in detail.

I acknowledge that I have received the Notice of Privacy Practices from Purcell Eye Clinic.

_____	_____	_____
Signature of patient, parent, or guardian	Printed name of patient, parent, or guardian	Date

EYE HEALTH HISTORY

Date of last eye exam _____	Optometrist _____
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Do you wear glasses? No Yes All the time Occasionally Reading Driving TV
Are there any tasks you find difficult performing with your glasses? No Yes

Do you wear contact lenses? No Yes

EYE HEALTH HISTORY CONTINUED

Do you experience or have you ever been diagnosed with any of the following?

- Blurred Vision - Distance Dry Eyes Lazy Eye Migraine Headache
 Blurred Vision - Near Eye Injury Loss of Vision Poor Color Vision
 Cataracts Glaucoma Macular Degeneration Poor Night Vision
 Crossed Eyes Headaches Other _____

Do you have family history of any of the following?

- Glaucoma Macular Degeneration Cataracts Color Blindness Retinal Detachment Blindness

Have you had any eye surgeries? None Cataract Surgery LASIK Other _____

Are you interested in any of the following? LASIK Contact Lenses

GENERAL HEALTH HISTORY

Name of Medical Doctor _____ Location of Medical Doctor _____
 Pharmacy Name _____ Height _____ Weight _____

Have you or a family member been diagnosed with any of the following?

Condition	Yourself	Family Member	Condition	Yourself	Family Member
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Ear, Nose, Throat Condition	<input type="checkbox"/>	<input type="checkbox"/>
Heart Condition	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Skin Condition	<input type="checkbox"/>	
Weight loss, fatigue, etc	<input type="checkbox"/>		Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes (Type ____)	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	
Thyroid Condition	<input type="checkbox"/>	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Gastrointestinal Condition	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Condition (e.g. depression, anxiety)	<input type="checkbox"/>	<input type="checkbox"/>
Genitourinary Condition	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Condition (e.g. asthma, COPD)	<input type="checkbox"/>	<input type="checkbox"/>

Please list any other general health condition not listed above _____

Pregnant? Yes No

Tobacco Use? Yes No

Alcohol Use? Yes No

Other substance use? Yes No

MEDICATIONS	ALLERGIES
List any medications you are currently taking, including eye drops _____ _____ _____ <input type="checkbox"/> No medications <input type="checkbox"/> See medication list attached	List any allergies to medications or other substances _____ _____ _____ <input type="checkbox"/> No Known Drug Allergies <input type="checkbox"/> Seasonal Allergies

Patient's Signature _____ Date _____