FLORIDA VISION

PATIENT INFORMATION

DATE ____________________

Patient's Name ____________________ Age ______ Date of Birth ____________ ☐ Male ☐ Female

Address ____________________ City ____________ State ______ Zip ________ Phone ____________

Occupation ____________________ if Student, grade ______ School ____________________

Employer ____________________ Address of Employer ____________________ Phone ____________

Marital Status ☐ Single ☐ Divorced ☐ Married ☐ Widowed

Name of Parent or Spouse ____________________

Preferred Payment Method ☐ Cash ☐ Check ☐ VISA ☐ MasterCard ☐ Discover ☐ American Express

Responsible Party (if other than patient) ____________________ Relation ____________

Chief Complaint ____________________

OK to contact by email? ☐ Yes ☐ No Email address? ____________________

Whom may we thank for referring you to us?

☐ Family Member ☐ Friend (name) ____________ ☐ Yellow Pages ☐ Other ☐ Advertisement (type) ____________

Social Security # ____________ Medicare # ____________ BC-BS# ____________

Other group health plan and insurance (if any) ____________________

Vision Care plan (if any) ____________________

HEALTH INFORMATION

Last Eye Exam ____________ by Doctor ____________ Last Physical Exam ____________ by Doctor ____________

Family Health History (Check all that apply)

	YOU	BLOOD RELATIVE		YOU	BLOOD RELATIVE
Glaucoma	☐	☐	Diabetes	☐	☐
Cataracts	☐	☐	High Blood Pressure	☐	☐
Crossed or Lazy Eye	☐	☐	Heart Problems	☐	☐
Blindness	☐	☐	Convulsions/Epilepsy	☐	☐
Cancer	☐	☐	Thyroid	☐	☐
Drug Allergies	☐	☐	List Any Other ____________		

Do you Smoke? ☐ Yes ☐ No Amount ____________ Do you drink alcohol? ☐ Yes ☐ No Amount? ____________

Are you taking medications? (includng eye drops, hormones, birth control) ☐ Yes ☐ No Please list ____________________

____

Have you ever had any injury or surgery to or around the eye? ☐ Yes ☐ No Please describe ____________________

____

Is this a contact lens exam? ☐ Yes ☐ No ☐ Possibly Are you interested in Laser Vision corrections? ☐ Yes ☐ No

____

OUT OF TOWN ADDRESS ____________________ ZIP CODE ____________

CITY/STATE ____________________ PHONE # ____________

USE THIS ADDRESS FROM ________ / ________ to ________ / ________

Payment is due when services are rendered. I understand I will be responsible for any additional fees incurred during the collection of payments made at later dates. I authorize any holder of medical or other information about me to release to any insurance carrier any informationn needed for this or a related claim. I permit a copy of this authorization to be used in place of the original; and request payment of medical insurance benefits either to myself or to the party who accepts assignment, in the event the doctor had to dilate or patch my eye. I am aware the following is possible: blurry vision, light sensitivity, decreased depth perception. For these reasons it may be suggested I not drive myself.

I understand that I am responsible for any amount not covered by insurance*

Signature: ____________________ Relationship to patient ____________________