Oviedo VISION Center

PATIENT'S NAME _____ ❑ MALE ❑ FEMALE
First Middle Initial Last

ADDRESS _____ EMAIL _____

CITY _____ STATE _____ ZIP _____ SPOUSE _____

DAY PHONE _____ CELL PHONE _____

DATE OF BIRTH ____/____/____ AGE _____ SOCIAL SECURITY NO. _____

OCCUPATION _____ EMPLOYER _____

PERSON RESPONSIBLE FOR PAYMENT _____ RELATIONSHIP TO PATIENT _____

PATIENT HOBBIES/INTERESTS _____

FAMILY PHYSICIAN _____ PHONE _____

MEDICAL INSURANCE CO. _____ VISION PLAN _____

SECONDARY INSURANCE CO. _____ POLICYHOLDER _____ DOB ____/____/____

REFERRED BY: Doctor: _____ Friend: _____

Family: _____ Other: _____

GENERAL HEALTH CONDITIONS - CURRENT OR PAST

	Yes	No		Yes	No
Allergies/Immune	❑	❑	GI/Digestive	❑	❑
Blood	❑	❑	Musculoskeletal	❑	❑
Cardiovascular	❑	❑	Arthritis	❑	❑
High Blood Pressure	❑	❑	Neurological	❑	❑
Ear/Nose/Throat/Mouth	❑	❑	Psychological	❑	❑
Diabetes	❑	❑	Respiratory	❑	❑
Thyroid	❑	❑	Asthma	❑	❑
Tobacco	❑	❑	Skin	❑	❑
Alcohol	❑	❑	Urinary/Kidney	❑	❑
Family w/above conditions	❑	❑	_____		

Details of above conditions:

VISION / EYE CONDITIONS

- ❑ Floaters/Spots
- ❑ Flashes of Light
- ❑ Dry Eyes
- ❑ Eyes Burn
- ❑ Eyes Itch
- ❑ Eyes Water
- ❑ Headaches-Frequency _____
- ❑ Eye Injury _____
- ❑ Eye Surgery _____
- ❑ Eye Diseases _____

Are you pregnant? _____ Other Conditions _____

Major Operations / Year _____

List any medications you are currently taking: _____

_____

ALL drug allergies: _____

ARE YOU INTERESTED IN CONTACT LENSES TODAY? ❑ NO ❑ YES

Which contacts are you currently wearing? ❑ Gas Permeable ❑ Bifocal ❑ Soft ❑ Disposable

Wearing time today _____ hours. Average wearing time per day _____ hours. Last time worn _____

PLEASE READ: I understand that I am responsible for my bill regardless of insurance. I authorize the release of this information to all my insurance carriers, and for the doctor to act as my agent in helping me obtain payment from my insurance carriers. I authorize payment directly to my doctor, and permit a copy of this authorization to be used in place of the original. I understand that I am responsible for any co-payments, deductibles and noncovered services.

_____

Signature (Patient or Guardian) Date