

We are pleased to have you as a part of our practice. The following information will aid our doctors in providing the most complete care possible.
If you are a returning patient, please only fill out information that may have changed.

PATIENT INFORMATION

Date _____

Name _____

Address _____

City _____ State _____ Zip _____

Phone (Home) _____

Phone (Work) _____

Phone (Cell) _____

Email _____

Sex M F Age _____ Birth date _____

SS# _____

Employer _____

Occupation _____

School _____

Grade _____

In case of emergency, contact _____

Relationship _____

Phone _____

PAYMENT / INSURANCE INFORMATION

Please circle the method of payment for today's professional services:

Cash Check VISA/MC DISCOVER

Who is responsible for this account _____

Relationship to the Patient _____

Insurance Company _____

Group # _____

Subscriber's Name _____

Birth date _____ SS# _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependents have insurance coverage with _____ and assign directly to Carillon Vision Care [Name of Insurance Company(ies)]

all insurance benefits, if any, otherwise payable to me for services/materials rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Carillon Vision Care may use my health care information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services/materials and determining insurance benefits or the benefits payable for related services/materials. This consent will end when my current treatment plan is completed or one year from the date signed below.

Print Name of Patient, Parent, Guardian or Personal Representative

Signature of Patient, Parent, Guardian or Personal Representative

Date _____ Relationship _____

EYE / VISION CONCERNS

Date of last exam _____ Doctor's Name _____

Reason for Today's Visit:

- Annual Check-up, Not Having Any Problems
- Need Stronger Prescription for Distance of Near Tasks
- Need Bifocals or Reading Spectacles
- Replace Lost or Broken Spectacles
- Need Second Pair Spectacles or Sunglasses
- Need More Contact Lenses
- Would Like to Try Contact Lenses
- Need Reading Glasses Over Contact Lenses
- Trouble Using Eyes Comfortably
- Other _____

Do you wear glasses? Yes No

- All the time Occasionally
- Distance tasks Near Tasks Computer

Do you wear contacts? Yes No Type _____ Replacement Schedule _____

Hours/Day Worn _____ Pairs Left _____ Solutions _____

To get a better sense of how you use your eyes, are there any hobbies, sports, or other recreational activities you participate in on a regular basis?

Please place a "✓" in any to indicate if you are experiencing any of the following.

<input type="checkbox"/> Blurred Vision – Distance	<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Blurred Vision – Near	<input type="checkbox"/> Headaches
<input type="checkbox"/> Burning Eyes	<input type="checkbox"/> Itching Eyes
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Light Sensitivity
<input type="checkbox"/> Crossed Eyes	<input type="checkbox"/> Loss of Vision
<input type="checkbox"/> Crusty Eyelids	<input type="checkbox"/> Macular Degeneration
<input type="checkbox"/> Discharge from Eyes	<input type="checkbox"/> Migraine Headaches
<input type="checkbox"/> Dizzy Spells	<input type="checkbox"/> Poor Night Vision
<input type="checkbox"/> Double Vision	<input type="checkbox"/> Red Eyes
<input type="checkbox"/> Dry Eyes	<input type="checkbox"/> Seeing Flashes
<input type="checkbox"/> Eye Infections	<input type="checkbox"/> Seeing Halos
<input type="checkbox"/> Eye Injury	<input type="checkbox"/> Styes
<input type="checkbox"/> Eye Strain	<input type="checkbox"/> Temporary Loss of Vision
<input type="checkbox"/> Fainting Spells, Blackouts	<input type="checkbox"/> Tired Eyes
<input type="checkbox"/> Floaters or Spots	<input type="checkbox"/> Twitching Eyelid
<input type="checkbox"/> Fluctuating Vision	<input type="checkbox"/> Watering Eyes

HEALTH HISTORY

Date of your last physical _____ Physician's name _____

Please place a "√" in any to indicate if you have had any of the following. Also, place a "√" in any to indicate if a blood relative has had any of the following problems (including parents, grandparents, uncle, aunts or siblings).

	Yourself	Family Members		Yourself	Family Members
AIDS/HIV	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Lazy Eye or Turned Eye	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	<input type="checkbox"/>
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>
Brain Tumor	<input type="checkbox"/>	<input type="checkbox"/>	Migraine Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Myasthenia Gravis	<input type="checkbox"/>	<input type="checkbox"/>
Chemical Dependency	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	Retinal Detachment	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell or Trait	<input type="checkbox"/>	<input type="checkbox"/>
Drug Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	Shingles	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Skin Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Condition	<input type="checkbox"/>	<input type="checkbox"/>
Eye Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Vision Training	<input type="checkbox"/>	<input type="checkbox"/>
Graves Disease	<input type="checkbox"/>	<input type="checkbox"/>			
Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No		Number of children _____
Head Injury	<input type="checkbox"/>	<input type="checkbox"/>	Do you use tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Heart Condition	<input type="checkbox"/>	<input type="checkbox"/>	Do you use alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Hepatitis (Type _____)	<input type="checkbox"/>	<input type="checkbox"/>			
Herpes	<input type="checkbox"/>	<input type="checkbox"/>			

ALLERGIES

Please place a "√" in any to indicate if you have any sensitivities or allergies in the categories below.

- Drugs (Please List) _____
- Foods (Please List) _____
- Environmental / Seasonal (Please include which season bothers you most) _____

MEDICATIONS / VITAMINS / SUPPLEMENTS

Please place a "√" in any to indicate if you use any prescribed or over-the-counter substances in the categories below.

- Eye Drops (Please List) _____
- Medications (Please List) _____
- Vitamins / Supplements (Please List) _____

— Thank You —