



Last Name: _____ First Name: _____ Middle Initial: _____

Street Address: _____ Apt#: _____

City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

YES, I would like to receive appointment reminders via text message.

Email Address: _____

Date of Birth: _____ Social Security # (last 4 digits): _____ Gender: M F

Marital Status: _____ Race: _____ Ethnicity: _____

Employer: _____ Occupation: _____

Family Physician/Office: _____

Who can we thank for referring you to our office? _____

Emergency Contact Information

Name: _____

Relationship: _____ Phone: _____

Insurance Information

Primary Card Holder's Name: _____ Relationship: _____

Address: _____ Date of Birth: _____

Social Security # (last 4 digits): _____ Contact Phone #: _____ Employer: _____

Notice of Privacy Practices, Authorization to Release Information to Insurance Company, & Acknowledgement of Responsibility for Payment

I acknowledge I have been offered or received a copy of this practice's NOTICE OF PRIVACY PRACTICES. I understand that Vision Specialists of Council Bluffs (VSCB) is a healthcare provider and may share my health information for treatment, payment, and healthcare operations.

I hereby assign all medical benefits (to which I am entitled) to the doctor caring for me. VSCB will file insurance coverage for me if I provide them with a copy of my current insurance card. This includes any health plans in which I am enrolled. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not they are paid by my insurance. I hereby authorize the holder of my medical and patient registration records to release any information needed to process my insurance claims. I understand that I am the guarantor of this account. A copy of my medical records can be requested in writing and will be provided to me or whomever I designate for \$15.00. I do acknowledge that there is a \$25.00 fee for returned checks. I am aware that if I do not have insurance coverage, I will be responsible for payment. Payment is due at the time of service.

Patient/Guarantor Signature: _____ Date: _____

Patient History

Reason for today's visit?

Date of last eye exam? _____

Currently wear glasses? Yes No

Currently wear contacts? Yes No

Have you or a family member (list relationship) experienced or been treated for any of the following?

Cataracts me family _____

Crossed Eye me family _____

Lazy Eye me family _____

Glaucoma me family _____

LASIK or RK me family _____

Macular Degeneration me family _____

Retinal Detachment me family _____

Other Eye Surgery _____

Eye Injuries _____

Are you currently experiencing, or have recently experienced, any of the following?

Blurry Vision (near or distance)

Loss of Vision

Loss of Side Vision

Double Vision

Glare / Halos / Light Sensitivity (day or night)

Flashes / Floaters in Vision

Tired Eyes

Excess Tearing / Watering

Itching

Redness

Dryness

Headaches

Do you work at a computer? Yes No

Do you spend time outdoors? Yes No

Do you plan on getting glasses today? Yes No

Do you plan on getting contacts today? Yes No

Hobbies: _____

Have you or a family member (list relationship) experienced or been treated for any of the following?

AIDS/HIV me family _____

Allergies me family _____

Arthritis me family _____

Asthma me family _____

Blood/Lymph Disorder me family _____

Cancer (Type) me family _____

Diabetes me family _____

Ears, Nose, Throat Conditions me family _____

Gastrointestinal Conditions me family _____

Heart Disease me family _____

High Blood Pressure me family _____

High Cholesterol me family _____

Kidney Disease me family _____

Lupus me family _____

Neurological Conditions me family _____

Psychiatric Disorder me family _____

Seizures me family _____

Skin Conditions me family _____

Stroke me family _____

Thyroid Dysfunction me family _____

Do you have any known allergies to medications?

Yes No If yes, please explain:

Current Medications (prescription and over-the-counter)

Height: _____ Weight: _____

Are you pregnant or nursing? _____

Do you smoke or chew tobacco? _____

Do you drink alcohol? _____

Do you use recreational drugs? _____