MEDICAL & EYE HISTORY

All information is confidential

Name _____ Occupation _____
Today's Date _____ Email _____

If you are new to our office who may we thank for referring you? _____

Social History

Do you use chewing tobacco products? Yes___ No___
Do you smoke? Yes___ No___
If yes, how many years? _____ How many packs/day? _____

Alcohol use (circle one) none social 1-2 drinks daily 3 or more

Please list your approximate height _____ and weight _____

Ocular History

When was your last eye exam? _____

Do you currently wear glasses?	Yes___	No___
Are you bothered by glare driving at night?	Yes___	No___
Do you currently wear contact lenses?	Yes___	No___
Are you interested in contact lenses?	Yes___	No___
Do you have any history of eye disease, injuries or surgery?	Yes___	No___

If yes, please explain_____

Family History

Do any family members have glaucoma, macular degeneration, diabetes or any other eye diseases? Yes___ No___ If yes, please explain _____

Medical History

How is your general health? _____Name of Physician: _____
Do you have any of the problems listed below? (Please circle Y for yes and N for No)

Ears/Nose/Throat	Y/ N	Blood disorders/lymph system	Y/ N
Skin disorders/ psoriasis/rosacea	Y/ N	Heart disease/ high blood pressure	Y/ N
Asthma/ emphysema	Y/ N	Fatigue/ weight loss or gain	Y/ N
Stomach/intestines/ ulcers	Y/ N	Diabetes	Y/ N
Genitals/ urinary tract/bladder	Y/ N	Depression/ anxiety	Y/ N
Muscles/skeleton	Y/ N	Headaches/ epilepsy	Y/ N
Immune disorders/Rheumatoid arthritis	Y/ N	Thyroid	Y/N

Other: _____

Please list any medications Rx and non-Rx you are using _____
_____
_____
_____

Please list any medications you are allergic to _____

Assignment of Benefits

_____
Name of Patient

I request that payment of authorized insurance benefits (including Medicare benefits) be made on my behalf to Vision Source for any services furnished to me. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated, my signature authorizes releasing information to the insurer. Vision Source accepts the charge determination of the Medicare carrier as the full charge, and I'm responsible for the deductible, co-insurance and non-covered services. I understand co-pays and all fees not covered by insurance are due at time of service.

_____ _____
Patient's Signature Date

NOTICE OF PRIVACY PRACTICES

We are sensitive to the fact that your medical information is private and we have taken steps to protect the privacy of your health information. We are obligated by law to give you notice of our privacy practices. The notice describes how we protect your health information and what rights you have regarding it.

I acknowledge that I received a copy of Notice of Privacy Practices for Vision Source of Wenatchee and Leavenworth Vision Source in Leavenworth.

_____ _____
Patient's Signature Date

PATIENT INFORMATION

Patient: _____ Date:_____

Address: _____

City: _____ State: ___ Zip: _____

Birthdate: ____/____/_____

Social Security Number: _____-_____-_____

Home Phone: _____ Cell Phone: _____

Email: _____

With your approval we will use either email or text cell phone to remind you of appointments and delivery notifications for eyewear and contact lenses.

EMPLOYMENT INFORMATION

Employer: _____ Occupation: _____

(If any of the below is different from above, please complete this section as well)

Parent/Guardian name: _____ Date:_____

Address: _____

City: _____ State: ___ Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Name of insurance subscriber: _____

Address: _____

Phone number: _____

Birthdate: ____/____/_____

Social Security Number of primary insurance subscriber: _____-_____-_____