SUNNYSIDE VISION SOURCE
A MEMBER OF Vision Source

Patient Name: _____ DOB: _____

City/State/Zip: _____ SSN: _____

Home Phone: _____

Cell Phone: _____ Email: _____

Work Phone: _____ Communication Preference:

☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Email

Employer: _____ Occupation: _____

Primary VISION Ins Co: _____ Primary MEDICAL Ins Co: _____

Primary VISION Ins ID: _____ Primary MEDICAL Ins ID: _____

☐ Check here if you are interested in LASIK Primary Care Provider: _____

Eye and Health History

Medical Allergies: _____

Current Medications: _____

_____

_____

Have you ever had any **eye injuries?** yes / no

Have you ever had any **eye diseases?** yes / no

Have you ever had any **eye surgeries?** yes / no

Please explain: _____

_____

Do you have a family history of any of the following conditions?

Blindness yes / no (relation): _____

Glaucoma yes / no (relation): _____

Cataracts yes / no (relation): _____

Macular Degeneration yes / no (relation): _____

Strabismus/Eye turn yes / no (relation): _____

Retinal Detachment yes / no (relation): _____

Other Eye Diseases yes / no (relation): _____

High Blood Pressure yes / no (relation): _____

Diabetes yes / no (relation): _____

Cancer yes / no (relation): _____

Systematic problems and many of the medical treatments for them may cause eye and vision changes. Do you have any problems in the following areas?

yes / no **Allergic/Immunologic** *(Lupus, hay fever, etc.)*

yes / no **Cardiovascular** *(heart, vessels, etc.)*

yes / no **General/Constitutional** *(fever, weight loss, etc.)*

yes / no **Endocrine** *(diabetes, thyroid, etc.)*

yes / no **Gastrointestinal** *(ulcers, intestinal disease, etc.)*

yes / no **Kidney, Bladder, or Urinary Tract**

yes / no **Ears, Nose, Throat** *(cold, sinus, etc.)*

yes / no **Blood/Lymph** *(bleeding disorder, anemia, etc.)*

yes / no **Skin** *(rosacea, skin cancers, psoriasis, etc.)*

yes / no **Musculoskeletal** *(arthritis, osteoporosis, back pain)*

yes / no **Neurological** *(MS, stroke, seizures, etc.)*

yes / no **Psychiatric** *(anxiety, depression, etc.)*

yes / no **Respiratory** *(asthma, emphysema, etc.)*

Social History:

Do you drink? yes / no / socially If so, ____ # per day.

Do you smoke? yes / no / quit If so, ____ # per day.

Marital Status:

never married / married / partnered / divorce / widowed

Hobbies: _____

_____

Diagnostic Issues- Please list any concerns about your glasses, contacts, eyes, or vision.

_____

_____

Payment & Insurance Obligations

NOTE: A deposit is required for service. Insurance will be billed as a courtesy. The patient is responsible for the balance of all services and materials. I understand that it is my responsibility to know whether I have applicable benefits, have met any deductibles, and understand any co-payment requirements under my current insurance plan. I, therefore, understand that I will be financially responsible for charges incurred at the time of this visit if I do not have the necessary benefits available. It is also my understanding that in many cases benefits payable under my insurance plan can only be determined after the insurance company has processed the claim; therefore, the amount I may owe is subject to change.

I also acknowledge that I have received and reviewed a copy of the Sunnyside/Happy Valley Vision Source notice of Privacy Practices.

Patient/Guardian Signature: **Date:**