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St. JoeVision

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Patient Information

Today's Date: _____

Last: _____

First: _____ MI: _____

SSN: _____

Sex: ☐ M ☐ F Birth Date: _____

☐ Single ☐ Married ☐ Widowed ☐ Minor

Street: _____

City: _____

State: _____ Zip Code: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Email: _____

Occupation (or Grade): _____

Employer (or School): _____

Spouse (or Parent)'s Name: _____

Spouse (or Parent)'s Work: _____

Whom can we thank for referring you or how did you hear of us? _____

What is the major purpose of this visit?

_____

_____

List hobbies / interests (helps us determine your visual needs): _____

_____

Insurance Information

Vision Insurance: _____
ID #: _____
Group #: _____
Subscriber's Name: _____
Subscriber's Birth Date: _____
Subscriber's Sex: ☐ M ☐ F
Patient's Relationship to Subscriber:
☐ Self ☐ Spouse ☐ Dependent ☐ Other

Medical Insurance: _____
ID #: _____
Group #: _____
Subscriber's Name: _____
Subscriber's Birth Date: _____
Subscriber's Sex: ☐ M ☐ F
Patient's Relationship to Subscriber:
☐ Self ☐ Spouse ☐ Dependent ☐ Other

Notice of Payment Policy

All professional fees, including exam and any additional testing recommended by the doctor, are due and payable the day they are provided. All material fees, including glasses and contact lenses, must be paid in full before the order can be placed.

If your fees are covered by a vision or medical plan for which we participate, any applicable deductibles, co-payments, and non-covered services and/or materials are due and payable on the date of your examination.

I understand that any fees incurred are my responsibility, unless otherwise prohibited by law, regardless of any insurance benefits, and said benefits are to be paid as stated in the above payment policy. Any collections and/or legal fees are my responsibility.

Signature: _____

Print: _____

Date: _____

The information in this confidential case history is critical to the evaluation of your vision and health.

Patient Medical History

Name of Family Physician: _____

Date of Last Physical Check-up: _____

Current Medications (RX or Over the Counter)

List name of medications including eye drops, vitamins, & birth control pills: _____

_____

_____

Do you have any allergies to medications? ☐ Yes ☐ No

If yes, what medications? _____

_____

Do you smoke? ☐ Yes ☐ No Packs/day: _____

Do you use alcohol? ☐ Yes ☐ No Drinks/day _____

Are you pregnant and/or nursing? ☐ Yes ☐ No

Have you had any surgeries? ☐ Yes ☐ No

If yes, please list: _____

_____

_____

Have you ever been diagnosed or treated for the following health problems? Check only if yes and specify.

	Yes	
Allergies	☐	_____
Arthritis	☐	_____
Asthma	☐	_____
Blood/Lymph	☐	_____
Cancer	☐	_____
Cardiovascular	☐	_____
Cholesterol	☐	_____
Diabetes	☐	_____
Digestive	☐	_____
Ears/Nose/Throat (Sinus)	☐	_____
Eczema/Rashes (Skin)	☐	_____
Genitourinary	☐	_____
High Blood Pressure	☐	_____
Kidney	☐	_____
Muscle/Bone	☐	_____
Neurological	☐	_____
Migraines	☐	_____
Psychological (Anxiety)	☐	_____
Respiratory (COPD)	☐	_____
Thyroid	☐	_____

Patient Eye History

Date of last eye exam: _____

Name of last eye doctor: _____

Do you wear glasses? ☐ Yes ☐ No

If yes:

☐ All of the time For: ☐ Distance ☐ Near ☐ Both

☐ Occasionally For: ☐ Distance ☐ Near ☐ Both

Are you interested in contact lenses? ☐ Yes ☐ No

Have you ever tried contact lenses? ☐ Yes ☐ No

Do you currently wear contact lenses? ☐ Yes ☐ No

What kind? _____

Solutions used: _____

Are you satisfied with the vision and comfort of your current contact lenses? ☐ Yes ☐ No

Have you ever experienced, been diagnosed, or treated for any of the following? Check only if yes.

☐ Cataracts
☐ Glaucoma
☐ Retinal Detachment
☐ Dry Eye
☐ Flashes of Light
☐ Crossed Eye / Eye Turn
☐ Eye Infections
☐ Blurry Vision
☐ Grittiness
☐ Headaches
☐ Macular Degeneration
☐ Corneal Abrasions
☐ Iritis / Uveitis
☐ Floaters / Spots
☐ Double Vision
☐ Lazy Eye
☐ Eye Injury
☐ Burning
☐ Itchiness
☐ Light Sensitivity
☐ Other eye disorders: _____

Family Medical / Eye History

Is there a family member with history of the following? Check only if yes and indicate relationship.

☐ Glaucoma _____
☐ Blindness _____
☐ Cataracts _____
☐ Macular Degeneration _____
☐ Retinal Detachment _____
☐ Lazy Eye _____
☐ Diabetes _____
☐ High Blood Pressure _____
☐ High Cholesterol _____
☐ Thyroid Disease _____
☐ Heart Disease _____
☐ Cancer _____