



CHOICE VISION
OPTOMETRY, INC.

WELCOME TO OUR OFFICE

Patient Name _____
Responsible Party Sign. _____
Date _____

REFERRED BY _____ DATE _____
(friend/family, walk in, insurance, advertisement, etc.)

PATIENT DEMOGRAPHICS

NAME _____ (last name) _____ (first name) _____ (MI) _____ SEX M F

DATE OF BIRTH ____/____/____ SOCIAL SECURITY # _____

STREET ADDRESS _____ (apt / unit #)

CITY _____ STATE _____ ZIP _____

HOME PHONE# _____ CELL PHONE / OTHER# _____

E-MAIL _____ (We will not give your e-mail address out to third parties)
(For periodic newsletters from Choice Vision and special offers / promotions / events)

EMPLOYER NAME _____ OCCUPATION _____

PRIMARY CARE PHYSICIAN _____ PHONE# _____

EMERGENCY CONTACT NAME _____

PHONE# _____ RELATIONSHIP _____

*** WHO IS FINANCIALLY RESPONSIBLE FOR THE ACCOUNT? (Circle one) Self Spouse Legal-Guardian

*** If someone other than yourself is responsible, please list: NAME _____ PHONE# _____

INSURANCE INFORMATION
(Please fill out below or provide copy of insurance card)

NAME OF SUBSCRIBER _____ RELATIONSHIP TO PATIENT _____

INSURANCE CARRIER _____ DATE OF BIRTH ____/____/____

CLAIMS ADDRESS _____

SUBSCRIBER# _____ GROUP # _____

SIGNATURE ON FILE

I HEREBY GIVE AUTHORIZATION FOR PAYMENT OF MEDICARE AND/OR ANY OTHER INSURANCE BENEFITS TO BE MADE DIRECTLY TO CHOICE VISION OPTOMETRY, INC FOR SERVICES RENDERED. I HEREBY AUTHORIZE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO SECURE PAYMENT OF BENEFITS. A PHOTOCOPY OF THIS AGREEMENT SHALL BE AS VALID AS THE ORIGINAL. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CO-PAYS, DEDUCTIBLES, COINSURANCE AND CHARGES NOT COVERED, OR DENIED BY INSURANCE.

SIGNED _____ DATE _____

PLEASE FILL OUT MEDICAL HISTORY ON OTHER SIDE

MEDICAL & OCULAR HISTORY QUESTIONNAIRE

Last Eye Exam (Date): YES NO
 Do you wear glasses?:
 How old are your current glasses?
 Do you wear Contact Lenses?: YES NO
 What Brand?.....
 How many hours / day do you wear your contacts?:.....
 What solution do you use?:.....
 How many times a week do you wear your contacts overnight?:.....
 Do you wear Sunglasses?:.....

DISEASE / CONDITION (Check all that apply)	Self		Family		(Relationship)
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment / Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asliann	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seizures / Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

SYMPTOMS (Check all that apply)

Headaches	<input type="checkbox"/>	Allergies / Htg/fever	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	Mucous discharge	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	Itchiness	<input type="checkbox"/>
Flashes / Floaters in vision	<input type="checkbox"/>	Sandy feeling	<input type="checkbox"/>
Tired eyes	<input type="checkbox"/>	Eyes Itch	<input type="checkbox"/>
Vision loss	<input type="checkbox"/>	Burning	<input type="checkbox"/>
Vision blurred	<input type="checkbox"/>	Foreign body sensation	<input type="checkbox"/>
Distorted / Halos	<input type="checkbox"/>	Excess tearing / watering	<input type="checkbox"/>
Side vision loss	<input type="checkbox"/>	Light sensitivity	<input type="checkbox"/>
Double vision	<input type="checkbox"/>	Eye pain or soreness	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	Infection of eyes or lids	<input type="checkbox"/>

Are you currently pregnant / breastfeeding?: YES NO N/A

MEDICATIONS: _____

ALLERGIES: _____

SURGERIES: _____