Confidential Patient Information Form

Thank you for choosing our practice for your eyecare needs. Please complete all pages of this form.
All information is confidential and allows for a more complete analysis of your health and visual system.
If you have any questions or concerns, do not hesitate to ask for assistance.

TODAY'S DATE _____

PATIENT INFORMATION

Last Name _____ First Name _____

Address _____

City _____ State _____ Zip _____

Date of Birth _____ Age _____ Gender ☐ Male ☐ Female

Preferred Phone Number _____ ☐ Home ☐ Work ☐ Cell

Secondary Phone Number _____ ☐ Home ☐ Work ☐ Cell

Email Address _____

Employer _____ Occupation _____

Emergency Contact Name _____ Phone _____

VISION (WELL CHECK) INSURANCE INFORMATION ☐ **None**

☐ VSP (Vision Service Plan) ☐ Superior ☐ EyeMed ☐ VCP (Vision Care Plan)

Other _____

Group # _____

Employer _____ Phone _____

Name of Insured _____ Relation to Patient _____

Social Security/ID # _____ Date of Birth _____

HEALTH INSURANCE INFORMATION ☐ **None**

☐ Aetna ☐ Benefit Planners ☐ Blue Cross Blue Shield (BCBS) ☐ Cigna ☐ Great West ☐ Guardian

☐ Humana ☐ Medicare ☐ PHCS ☐ Principal ☐ Tricare ☐ UnitedHealthcare (UHC)

Other _____

Group # _____

Employer _____ Phone _____

Name of Insured _____ Relation to Patient _____

Social Security/ID # _____ Date of Birth _____

RESPONSIBILITY OF PAYMENT
I understand the coverage quoted to Southwest Vision by my vision and/or health insurance company is not a guarantee of payment. Payment is based on eligibility and benefits at the time of service. I agree to pay any amount my insurance company denies or indicates is patient responsibility.

_____
Signature

Date of Last Eye Exam _____ Last Eye Doctor _____

Reason for Today's Visit _____

Are you planning to get eyeglasses today? Y / N

If not a contact lens wearer, are you interested in trying contact lenses today? Y / N

Are you interested in learning about Laser Vision Correction? Y / N

CONTACT LENS HISTORY

Do you currently wear contacts? Y / N Hours per day _____ Days per week _____ Hours worn today _____

Brand or type you are currently wearing _____ Replacement Schedule _____

If not wearing contacts now, reason for stopping _____

EYEGLASS HISTORY (Please Circle All That Apply)

Do you currently wear eyeglasses?	Y / N	Part-time	Full-time	Distance Only	Near Only
Eyeglasses being worn now are...?		Single Vision	Bifocals	Progressive	Trifocals
Do you wear sunglasses?	Y / N	Are your sunglasses your most recent prescription?			Y / N

PERSONAL HEALTH HISTORY (Please Check All That Apply)

Current Eye Symptoms / Conditions

☐ **None**			
☐ Distance Vision Blurred	☐ Headaches	☐ Eye Pain / Soreness	☐ Retinal Detachment
☐ Near Vision Blurred	☐ Excess Tearing	☐ Sandy / Gritty Feeling	☐ Glaucoma / Ocular Hypertension
☐ Floaters / Spots	☐ Dryness	☐ Itching	☐ Loss of Side Vision
☐ Amblyopia / Lazy Eye	☐ Glare / Light Sensitivity	☐ Redness	☐ Macular Degeneration
☐ Tired Eyes	☐ Foreign Body Sensation	☐ Mucous Discharge	☐ Vision Distortions

Other: _____

Ocular Surgeries:

Procedure _____ Year _____ Which Eye _____ Dr. _____

Procedure _____ Year _____ Which Eye _____ Dr. _____

Current Primary Care Physician: _____ Last Visit _____

Phone Number _____ Fax Number _____

Current Specialty Care Physician: _____ Last Visit _____

Phone Number _____ Fax Number _____

Condition Treated or Monitored _____

Systemic History ☐ **None**

Cardiovascular
- ☐ Elevated Cholesterol
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Congestive Heart Failure

Head / ENT
- ☐ Migraines
- ☐ Sinusitis
- ☐ Dizziness / Vertigo
- ☐ Chronic Cough

Endocrine
- ☐ Diabetes
- ☐ Thyroid Imbalance
- ☐ Gout
- ☐ Renal Disease

Skin and Integumentary
- ☐ Acne Rosacea
- ☐ Lupus
- ☐ Psoriasis
- ☐ Cancer

Hematologic / Lymphatic
- ☐ Leukemia
- ☐ Temporal Arteritis
- ☐ Lymphatic Disorder
- ☐ Sickle Cell Disease

Respiratory
- ☐ Asthma
- ☐ COPD
- ☐ Lung Cancer
- ☐ Lung Disorder

Gastrointestinal
- ☐ Cancer: Colon, Liver
- ☐ Colitis
- ☐ Hepatitis
- ☐ Irritable Bowel

Genitourinary
- ☐ Menopause
- ☐ Prostate Cancer
- ☐ Cervical Cancer
- ☐ Breast Cancer

Neurological
- ☐ Bell's Palsy
- ☐ Multiple Sclerosis
- ☐ Parkinson's Disease
- ☐ Seizures
- ☐ Brain Tumor

Immunological
- ☐ AIDS/HIV
- ☐ Sarcoidosis
- ☐ Sjogren's Syndrome
- ☐ Syphilis
- ☐ Tuberculosis

Mental
- ☐ Alzheimer's
- ☐ Bi-Polar Disorder
- ☐ Learning Disability
- ☐ Depression
- ☐ Schizophrenia

Musculoskeletal
- ☐ Arthritis
- ☐ Rheumatoid Arthritis
- ☐ Muscular Dystrophy

Current Medications:

1. _____ **2.** _____

3. _____ **4.** _____

5. _____ **6.** _____

Drug Allergies:

1. _____ **2.** _____

3. _____ **4.** _____

Height _____ **Weight** _____ **Blood Pressure (if known)** _____/_____

Social Habits:

Alcohol Use	☐ None	☐ Infrequent	☐ Frequent	☐ Daily	☐ Dependence	☐ Decline to report
Tobacco Use	☐ None	☐ Infrequent	☐ Frequent	☐ Daily	☐ Dependence	☐ Decline to report
Narcotic Use	☐ None	☐ Infrequent	☐ Frequent	☐ Daily	☐ Dependence	☐ Decline to report

FAMILY HEALTH HISTORY

	Relationship To Patient		Relationship To Patient
☐ Amblyopia / Lazy Eye	_____	☐ Diabetes	_____
☐ Blindness	_____	☐ Heart Disease	_____
☐ Cataracts	_____	☐ Stroke	_____
☐ Glaucoma	_____	☐ Thyroid Disease	_____
☐ Retinal Detachment	_____	☐ Cancer	_____
☐ Macular Degeneration	_____	☐ Arthritis	_____

ACKNOWLEDGEMENT
OF
NOTICE OF PRIVACY PRACTICES

The law requires that Southwest Vision make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

PLEASE **CHECK ONLY THE ONE BOX** THAT APPLIES TO YOU

- ☐ I have read or had explained to me Southwest Vision's Notice of Privacy Practice and agree to continue my care with Southwest Vision under said terms.

- ☐ I have read or had explained to me Southwest Vision's Notice of Privacy Practice and do not wish to continue my care with Southwest Vision under said terms.

- ☐ The Notice of Privacy Practice could not be read due to the emergent nature of the care of other reason described as

  _____

  _____

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

_____ _____

Patient Date

If you are signing as a personal representative of the patient, please indicate your relationship:

_____ _____

Representative Relationship to Patient

In addition, HIPAA requires the patient's prior authorization in order to release medical information to another person. This includes, but is not limited to, medical records, glasses or contact lenses prescriptions, receipts, or any other documents with personal patient information.

Please list below the person or persons you are allowing access to your medical records and personal information:

_____ _____

_____ _____