# 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 | _____ |

## Southwest Vision Recommends Optical Coherence Tomography

**It is recommended** by the doctors at Southwest Vision to get a through baseline of your optic nerve and macula at the age of 50, regardless of family history of retinal eye disease.

While we do assess these structures in our routine exam tests, there is a test called the Optical Coherence Tomography (OCT) that is able to view each individual layer in a unique way, similar to an MRI. In many instances we can detect very early macular degeneration and/or glaucoma with this test alone.

If you have a family history for either of these conditions this test will allow you to understand your risk factor more comprehensively, and can be done at any age.

Unfortunately, insurance plans will not cover this test when done as a screening. If we do find something concerning, we can then bill it to insurance. If the results are normal, it will be an expense to you as the patient.

**The cost of this test is $75.00**

◯ YES, I want OCT Testing.

◯ NO, I decline OCT Testing.

## Acknowledgement of Policies for Privacy Practices

Federal law requires that Southwest Vision make every effort to inform you of your rights related to your personal health information. By signing below, I acknowledge that 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 am signing it voluntarily.

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, eyeglasses or contact lens prescriptions, receipts or any other documents with personal information.

**Please list any person or persons you wish to allow access to your medical records and personal information.**

(1) _____ (2) _____

_____ _____

**Patient / Guardian Signature** **Date**