VANCE VISION CLINIC

Patient History

Dustin C. Vance, O.D.
Optometric Physician

Patient's Name _____ **Birthdate:** _____

Mailing Address: _____

_____

(City) **(State)** **(Zip Code)**

Parent/Guardian: _____

(if patient is a minor)

Home Phone #: (___)_____ **Work/Cell Phone #: (___)**_____

E-mail address: _____ Occupation: _____

Emergency Contact # _____ *Family member preferred*

Please provide your best available Emergency contact number.

Do you have vision insurance? Y / N Do you have medical insurance ? Y / N

Insurance company_____ **Policy Holder**_____

Policy Holder's Birthdate:_____ **Relationship to Policy Holder**_____

Policy holders SSN _____-____-_____ **YOUR SSN#:** _____-_____-_____

We require payment in full (copayments and deductibles) at the time services are rendered. Please provide copies of all insurance cards to the receptionist. We will make every effort to bill your insurance. You will be responsible for any remaining balance.

Eye History:

Date of last eye examination: _____ **Doctor:** _____

Date of last medical examination: _____ **Doctor:** _____

Do you currently wear: glasses? YES NO contact lenses? YES NO

Do you have Diabetes or Take any medications for Diabetes or "Blood Sugar"? YES or NO
(*please Circle one)*

Do you Object to having your eyes Dilated today? YES or NO (please circle one)

Have you (or family) had the following? (Check all that apply)	***Self***	***Family***
Amblyopia (lazy eye)	□	□
Macular Degeneration	□	□
Glaucoma	□	□
Diabetic Retinopathy	□	□
Retinal Detachment	□	□
Retinal Disease	□	□
Blindness	□	□

Other (please list)_____

Have you had eye surgery for the following? (Check all that apply)	
Cataract	□
Trauma	□
Laser Vision Correction	□
Foreign Body Removal	□
Retinal Detachment	□

Other (please list)_____

Please list any MEDICATIONS you are taking (including eye drops & over the counter)

_____

_____

Are you allergic to any medications? YES NO please list: _____

Are you pregnant and/or nursing at this time? YES NO

Social History:

Do you drive: YES NO If yes, do you have visual difficulty when driving? YES NO

Do you use tobacco products? YES NO Type/amount/how long: _____

Do you drink alcohol? YES NO Type/amount/how long: _____

I hereby declare that the above information is true to the best of my knowledge.

Patient (or guardian) Signature _____ **Date** _____

Review of Systems:

Do you currently, or have you ever had any of the following?

(CIRCLE all that apply)

Eyes (Ocular symptoms)
Eye pain or soreness
Fatigue/tired eyes
Dry/gritty feeling
Redness
Burning
Itching
Excess watering
Mucous discharge
Chronic infections
Squinting
Glare light sensitivity
Halos around lights
Double vision
Loss of vision
Blurred vision
Flashes/floaters

Constitutional
Fever
Weight loss or gain

Skin
Rosacea
Metal allergies

Ear, Nose, Throat, Mouth
Allergies/hay fever
Sinus infections
Hearing loss

Respiratory
Asthma
Chronic bronchitis
Emphysema

Vascular/Cardiovascular
Heart disease/problems
High blood pressure
Stroke

Gastrointestinal
Acid Reflux
Intestinal Problems
Liver/spleen problems

Endocrine
Thyroid/other glands
Diabetes

Genitourinary
Genitals/kidney/bladder

Lymphatic/hematologic
Anemia
Bleeding disorders

Bones/joints/muscles
Rheumatoid arthritis

Neurological
Headaches/migraines
Seizures
Multiple Sclerosis
Alzheimer's/dementia
Parkinson's

Cancer
Type: _____

Psychiatric

Immune system

Dr Initials_____

PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

I give additional permission to Vance Vision Clinic staff to discuss/release details of my treatment/protected health information with/to the following person/(s):_____

Relation to patient _____

Signed this _____ _____ of the year _____

MONTH DAY YEAR

Print Patient Name _____

Signature _____

Relationship to Patient _____

(*if other than self)*