OVIEDO VISION CENTER

PATIENT'S NAME _____ ❑ MALE ❑ FEMALE
First Middle Initial Last

ADDRESS _____
Street City State Zip Code

DATE OF BIRTH _____/_____/_____ MARITAL STATUS: ❑ SINGLE ❑ MARRIED ❑ DIVORCED/OTHER

OCCUPATION _____ EMPLOYER _____

DAY PHONE _____ SOCIAL SECURITY NO. _____

HOW WOULD YOU LIKE US TO SEND YOU REMINDERS ABOUT PICKUPS AND/OR FUTURE APPOINTMENTS?
BY: ❑ PHONE ❑ MAIL ❑ TEXT ❑ EMAIL _____

RESPONSIBLE PARTY FOR PAYMENT _____ RELATIONSHIP TO PATIENT _____

MEDICAL INSURANCE _____ VISION PLAN _____

SECONDARY INSURANCE _____ POLICY HOLDER_____ DOB ____/____/____

REFERRED BY: ❑ DR:_____ ❑ FAMILY/ FRIEND _____ ❑ OTHER _____

PCP: _____ PREFERRED PHARMACY: _____

GENERAL MEDICAL CONDITIONS - CURRENT OR PAST

	SELF	FAMILY		SELF	FAMILY
Cancer	❑	❑	GI / Digestive	❑	❑
Multiple Sclerosis	❑	❑	Urinary / Kidney	❑	❑
Epilepsy	❑	❑	STDs / Herpes	❑	❑
Neurological	❑	❑	Musculoskeletal	❑	❑
Physiological	❑	❑	Arthritis	❑	❑
Cardiovascular	❑	❑	Diabetes	❑	❑
Stroke	❑	❑	Thyroid	❑	❑
High Blood Pres.	❑	❑	High Cholesterol	❑	❑
Respiratory	❑	❑	Anemia	❑	❑
Asthma	❑	❑	Other _____	❑	❑

DESCRIBE: _____

VISION / EYE CONDITIONS

❑ Cataracts
❑ Macular Degeneration
❑ Glaucoma
❑ Headaches
❑ Diabetic Retinopathy
❑ Dry Eye
❑ Infection / Inflammation
❑ Flashes / Floaters
❑ Iritis / Uveitis / Eye Pain
❑ Retina Defects / Degen.
❑ Eye Injury _____
❑ Eye Surgery _____

CURRENT MEDICATIONS: _____

ALL DRUG ALLERGIES: _____

SOCIAL HISTORY:

Are you: Pregnant ❑ Y ❑ N Nursing ❑ Y ❑ N Do you use: Alcohol ❑ Y ❑ N Tobacco ❑ Y ❑ N

DO YOU CURRENTLY WEAR CONTACTS ❑ Y ❑ N ARE YOU INTERESTED IN CONTACT LENSES? ❑ Y ❑ N

PLEASE READ: I understand that I am responsible for my bill regardless of insurance. I authorize the release of this information to all my insurance carriers, and for the doctor to act as my agent in helping me obtain payment from my insurance carriers. I authorize payment directly to my doctor, and permit a copy of this authorization to be used in place of the original. I understand that I am responsible for any co-payments, deductibles and noncovered services.

_____
Signature (Patient or Guardian) Date

I have received the **NOTICE OF PRIVACY PRACTICES** and have been provided an opportunity to review it.

_____
Signature (Patient or Guardian) Name of Authorized Persons