

VISION SOURCE

**Altoona EyeCare
EyeCare Associates of Ankeny
Johnston EyeCare**

Thank you for choosing our practice for your eye care needs. Please complete this form in ink. If you have any questions, do not hesitate to ask for assistance. All information is confidential. **(Please print)**

PATIENT INFORMATION

Date _____

First MI Last Nickname _____

Address _____ City _____ State _____ Zip _____

Birthdate _____ Male Female

Primary Language: English Other _____
Race: American Indian or Alaska Native Asian Black or African American Native Hawaiian or Other Pacific Islander
 White All Other Races Declined to specify
Ethnicity: Hispanic or Latino Not Hispanic or Latino Declined to specify
How did you hear about us? Facebook Chamber of Commerce Word of Mouth Radio Advertising Driving by/ saw sign
 Online Search Yelp Magazine Yellow Pages Other

Please check your preferred phone contact: HOME CELL WORK

Home Phone # _____ Cell Phone # _____ Work Phone # _____

E-mail address _____ Decline

Preferred communication for your next appointment Email Text US Mail

Marital Status: Single Married Widowed Divorced Other

Employer/School _____ Occupation/Student _____ Full Time Part Time

Emergency Contact: _____ Phone # _____ Relationship _____

IF PATIENT IS A MINOR

Mother's name _____ Address _____

Home# _____ Cell# _____ Work# _____ Employer _____

Father's name _____ Address _____

Home# _____ Cell# _____ Work# _____ Employer _____

INSURANCE INFORMATION (Please provide cards upon arrival)

Insurance Company Name _____ Vision coverage: Yes No

Medical coverage: Yes No

Name of primary insured _____ Employer _____

Birth date _____ SSN# _____ Relationship to patient _____

DO YOU HAVE ANY ADDITIONAL INSURANCE?

Insurance Company Name _____ Vision coverage: Yes No

Medical coverage: Yes No

Name of primary insured _____ Employer _____

Birth date _____ SSN# _____ Relationship to patient _____

PLEASE COMPLETE BACK OF THIS PAGE

Health History

Date of last vision exam _____ Name of eye doctor _____

Reason for today's exam _____ Name of medical doctor _____

Do you or anyone in your immediate family have a history of the following? Please use abbreviations to identify self or family member:

S/self **M**/mother **F**/father **B**/brother **SS**/sister **GM**/grandmother **GF**/grandfather **A**/aunt **U**/uncle

____ Cataracts ____ Macular degeneration ____ Glaucoma ____ Blindness ____ Turned or lazy eye

____ Diabetes ____ Heart disease or stroke ____ High blood pressure ____ Thyroid disease ____ Lupus or MS

____ Asthma ____ Lung problems ____ Hay fever ____ Sinus Condition ____ Arthritis

____ Cancer or tumor – Type _____ ____ Skin condition ____ Frequent headaches ____ Hepatitis ____ HIV

List all prescription medications you are currently taking _____

List vitamins or non-prescriptions medications you are currently taking _____

List known drug allergies _____ Other allergies _____

List recent surgeries (past 5 years) _____

Do you have any of the following conditions involving your eyes? Please check all that apply.

____ Eye surgery ____ Eye or head injury ____ Severe pain ____ Eye infection or disease ____ Eye strain

____ Poor near vision ____ Poor distance vision ____ Double vision ____ Light sensitivity ____ Halos ____ Redness

____ Floaters or spots ____ Light flashes ____ Eyes burn, itch, water ____ Discharge from the eye ____ Glare

If you have check any of the above, please explain _____

____ Height Do you: ____ Smoke ____ Consume Alcohol ____ Use recreational drugs

Do you currently wear glasses? ____ Yes ____ No How old are they? _____

Have you ever had difficulty adjusting to new glasses? ____ Yes ____ No Describe briefly: _____

When do you wear your glasses? ____ All the time ____ Reading & near work ____ Distance tasks only ____ Computer ____ Work safety ____ Sports

Do you use a computer or video display terminal? ____ Yes ____ No If yes, how many hours per day? _____

Do you currently have: ____ 2nd pair glasses (for backup or emergency) ____ Sunglasses ____ Sport glasses ____ Work safety glasses

What hobbies or sports do you participate in? _____

Are you interested in trying contact lenses? _____ Do you wear contacts now? _____ Have you ever worn contacts? _____

If so, what style? ____ Soft ____ Gas permeable ____ Colored What cleaning/disinfecting system do you use? _____

How many hours a day do you wear your contacts? _____ How often do you replace your contact lenses? _____

What brand of contacts are you currently wearing? _____ Are you interested in corrective eye surgery? (Lasik/Laser) _____

Authorization

I certify that the above information is accurate and complete to the best of my knowledge. I understand that providing the incorrect information can be dangerous to my health. I authorize the doctor to release any information, including the diagnosis, and the records of any treatment or examination rendered to me or my child during the period of such eye care, to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the eye doctor or ophthalmic group insurance benefits otherwise payable to me. I understand that my eye care insurance carrier may pay less than the actual bill for my services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____
Signature of patient (or parent if a minor)

_____ Date