

Patient Intake Form

General Information

Patient Name: _____ DOB: _____ Date: _____

Parent/Guardian Name: _____ DOB: _____

Phone: _____ Address: _____ City: _____ State: _____

Reason for Visit: _____

Do you wear contact lenses and/or would like an exam for contact lenses? (Extra Fee) Yes No

Patient History

Please review and check any conditions in the following body systems

Constitutional/General

- Developmental Delay
- Cancer

Ear, Nose, Throat

- Hearing loss
- Sinusitis
- Dry Mouth

Neurological

- Epilepsy
- Dementia
- Migraine
- Autism Spectrum

Psychiatric

- Depression
- ADHD
- Anxiety Disorder
- Bipolar Disorder

Cardiovascular/Heart

- High Blood Pressure
- Stroke

Respiratory/Breathing

- Asthma
- Emphysema
- COPD
- Sleep Apnea

Gastrointestinal

- Ulcer
- Crohn's Disease

Genitourinary

- Kidney Disease
- Prostate Cancer
- HIV/AIDS
- STD
- Herpes

Muscle/Skeletal

- Arthritis
- Fibromyalgia
- Osteoporosis

Skin/Integumentary

- Eczema
- Rosacea
- Herpes
- Shingles

Endocrine

- Thyroid
- Diabetes T1/ T2
borderline

Blood/Liver

- Anemia
- High Cholesterol

Allergy Immunologic

- Rheumatoid Arthritis
- Environmental
- Lupus
- Sjogren's Syndrome

Pregnant or Breast Feeding? YES or NO

Ocular History (List any eye surgeries, diseases, or other issues):

Medications (Please provide a list to staff if taking more than three):

Medication Allergies: None _____

Pharmacy: _____ Primary Care Physician: _____

Family History: Diabetes Hypertension Cancer
 Macular Degeneration Glaucoma Cataract

Social History: Occupation: _____

Hobbies: _____

Do you drink alcohol? If yes, how much per day? _____

Do you smoke tobacco? If yes, how much? _____

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Insurance Information

Primary Policy Holder Name: _____ Policy Holder DOB: _____

Relation to Policy Holder: _____ Policy Holder SSN: _____

Primary Vision: _____ Vision ID# _____

Secondary Vision: _____ Vision ID# _____

When this type of insurance is used, it covers routine eye examinations, such as regular check-ups and prescription for glasses or contact lenses.

Primary Policy Holder Name: _____ Policy Holder DOB: _____

Relation to Policy Holder: _____ Policy Holder SSN: _____

Primary Medical: _____ Medical ID# _____

Secondary Medical: _____ Medical ID# _____

When this type of insurance is used, it covers a medical problem related to your eyes. This includes situations where there's a medical sign, symptoms, or ongoing care for a specific eye condition. There are some cases where it can cover routine eye examinations, except prescription (Refraction) for glasses or contact lenses.

Disclosure of Health Information

You have the right to request that we restrict disclosure of your Protected Health Information to certain individuals involved in your care such as family members, friends, or power of attorney.

I **DO NOT** wish any information to be given to anyone.

Information may be shared with only the following person(s):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature: _____ Date: _____

(Patient, Parent, Legal Guardian/POA)