

**FULL CIRCLE VISION CARE**

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Spouse/Parent: \_\_\_\_\_

Age:    Male    Female    Eye Color: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

City:                      State:                      Zip: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Social Security Number:    -    - \_\_\_\_\_

Vision Insurance: \_\_\_\_\_

Medical Insurance: \_\_\_\_\_

Medical Physician: \_\_\_\_\_

Occupation: \_\_\_\_\_

Email: \_\_\_\_\_

**OCULAR HISTORY**

Date of Last Eye Exam: \_\_\_\_\_

Date of Last Pair of Glasses: \_\_\_\_\_

History of Eye Trauma: \_\_\_\_\_

History of Eye Surgery: \_\_\_\_\_

Eye Diseases (Glaucoma, Cataracts, Retinal Detachment, Macular Degeneration)

Please list any that apply: \_\_\_\_\_

Do you have dry eyes? \_\_\_\_\_

Blurred Vision? \_\_\_\_\_

\*Are you interested in Laser Vision Correction? \_\_\_\_\_

**MEDICAL CONDITIONS (PATIENT) CIRCLE YES or NO**

Cancer	YES	NO	Migraine	YES	NO	Asthma	YES	NO
Fatigue	YES	NO	Depression	YES	NO	Emphysema	YES	NO
Hearing Loss	YES	NO	Anxiety	YES	NO	Sleep Apnea	YES	NO
Blindness	YES	NO	Skin Disorder	YES	NO	GI Disorder	YES	NO
Sinusitis	YES	NO	Hypertension	YES	NO	Pregnant	YES	NO
Dry Mouth	YES	NO	Heart Disease	YES	NO	Arthritis	YES	NO
Epilepsy	YES	NO	Vascular Disease	YES	NO	Diabetes	YES	NO
Tumor	YES	NO	Cholesterol	YES	NO	Anemia	YES	NO
Stroke	YES	NO	Kidney Disease	YES	NO	Ulcer	YES	NO

**SOCIAL HISTORY CIRCLE YES or NO**

Smoking:                      YES    NO

Drugs:                      YES    NO

Alcohol:                      YES    NO

Amount of computer/screen time per day: \_\_\_\_\_

Hobbies: \_\_\_\_\_

**PAST AND PRESENT MEDICAL HISTORY**

Environmental Allergies: \_\_\_\_\_  
 Medication Allergies: \_\_\_\_\_  
 Current Medications: \_\_\_\_\_  
 Previous Surgeries: \_\_\_\_\_  
 Eye Medications: \_\_\_\_\_

**FAMILY HISTORY** Place an X with whom it applies

	<b>Grandparent</b>	<b>Father</b>	<b>Mother</b>	<b>Brother</b>	<b>Sister</b>	<b>Son</b>	<b>Daughter</b>
Hypertension							
Diabetes							
Cancer							
Asthma							
Heart Disease							
Hypercholesterolemia							
Thyroid Disorder							
Glaucoma							
Macular Degeneration							
Cataract							
Keratoconus							
Retinal Detachment							
Fuchs' Corneal Dystrophy							
Lazy Eye							
Blindness							

**MEDICARE, MEDICAID, BLUE CROSS BLUE SHIELD, VSP, AND ALL OTHER INSURANCE PATIENTS/  
 NON-INSURANCE PATIENTS:**

"I authorize any holder of medical or other information about me to be released to the Social Security Administration and Health Care Administration (for Medicare patients) or to my insurance company and/or it's intermediaries, any information needed for related claims. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to either myself or to the party who accepts assignment."

In the event of a denial or rejection of this claim by insurance company, I understand that the payment of said claim will be my responsibility.

**ALL PATIENTS WITH INSURANCE ARE RESPONSIBLE FOR THE \$40.00 REFRACTION FEE IF THAT IS NOT COVERED BY SAID INSURANCES.**

I acknowledge that I was offered a copy of the Notice of Privacy Practices.

Date: \_\_\_\_\_

**SIGNATURE OF GUARANTOR/PATIENT**

I hereby give approval to disclose any or all of my medical information to:

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

REFERRED BY: \_\_\_\_\_