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

	Grandparent	Father	Mother	Brother	Sister	Son	Daughter
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 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: _____