

POINTE VISION CARE, P.C.
PATIENT INFORMATION FORM

Personal Information:

Circle One: Mr. Mrs. Miss Dr. SS# _____
Last Name: _____ First: _____ MI _____
Address: _____ Home Phone: _____
City: _____ State: _____ Zip: _____
Occupation: _____ Cell/Work Phone: _____
Employer: _____ Birthdate: _____

Insurance Information:

****Primary VISION Carrier:** _____
Insured Name: _____ Birthdate: _____
ID#/Social Security #: _____ Group #: _____
****Primary MEDICAL Carrier:** _____
Insured Name: _____ Birthdate: _____
ID#/Social Security #: _____ Group #: _____

How did you hear about us? _____

Medical History:

Do you have problems with any of the following systems? Eyes Y/N

Gastrointestinal	Y/N	Nervous	Y/N	Mental	Y/N
Ears/Nose/Throat	Y/N	Muscles	Y/N	Bladder/Urinary Tract	Y/N
Endocrine (Diabetes)	Y/N	Cardiac/BP	Y/N	Respiratory/Asthma	Y/N
Blood/ Lymph	Y/N	Skin	Y/N	Allergy/Sinus	Y/N

Are you currently taking any medication? Please list _____

Do you use cigarettes/tobacco? Y/N Alcohol? Y/N
Occupational Hazards? Y/N Do you need safety glasses? Y/N

Family History: Diabetes Y/N Glaucoma Y/N Macular Degeneration Y/N

Other: _____

Previous eye injury or eye surgery? Y/N Explain: _____

Ocular History: Are you experiencing any of the following:

Blurred vision	Y/N	Headaches	Y/N	Loss of Vision	Y/N	Eye Pain	Y/N
Double Vision	Y/N	Floaters	Y/N	Flashing Lights	Y/N	Other:	_____
Sandy/Grittiness	Y/N	Dry Eyes	Y/N	Itchy/Watery Eyes	Y/N		_____

Do you wear glasses? Y/N Contact Lenses? Y/N Type? _____
Are you interested in contact lenses? Y/N Refractive surgery? Y/N

In case of emergency, name of closest relative **not living with you**
Phone _____

Relationship to patient _____

How do you plan to pay for services today? ___ cash ___ check ___ credit card

PLEASE NOTE: PAYMENT IS REQUIRED AT TIME SERVICES ARE RENDERED.

I am aware that I am responsible for payment of services not covered by my insurance. I am also aware that prior insurance authorization DOES NOT guarantee payment by my insurance and if there are any questions about insurance eligibility, I am responsible for all fees from my visit.

Signature: _____ Date _____