POINTE VISION CARE

WELCOME TO OUR OFFICE

Patient PVC # _____

Name (Patient)

Street

City State Zip

Parent/Guardian

Phone

Employer (Patient)

Occupation(Patient)

Email address

Today's Date _____

Patient's Date of Birth _____ Age_____

Sex: M F

Ethnicity:_____

Medical History Do you have any problems?

Arthritis	Y	N	Fibromyalgia	Y	N
Allergies/Sinus	Y	N	Heart Disease	Y	N
Cancer	Y	N	Migraines	Y	N
Depression/other	Y	N	Diabetes	Y	N
Skin disorder	Y	N	Digestive	Y	N
Neurological	Y	N	Blood Pressure	Y	N

Current Medications (Rx and over the counter)

Do you smoke cigarettes? Y N Do you use alcohol? Y N

Do you use eye drops? Y N

List any medications you are allergic to:

★★★★★★★★★★

Insurance Information

Vision Plan and ID #

Medical Ins. and ID #

Name of Insured

Insured's Employer

Insured's Date of Birth

Insured's Last 4 #'s of SS# _____

Patient's relationship to insured: Circle

Self Spouse Child Other

Patient's Marital Status: Circle

Single Married Other

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Would you like to have the Eye Screen Photographic Examination (advanced digital retinal photos)? Y N

Would you like to have the Visual Field Test? Y N

Both test: $39 Eye Screen: $25 Visual Field: $19

If you do not want the test please sign here:

Family Medical History

Do any of your family members have:

Diabetes	Y	N	Cataract	Y	N
Ocular tumors	Y	N	Glaucoma	Y	N
High blood pressure	Y	N	Retinal Detachment	Y	N
Macular Degeneration	Y	N	Blindness	Y	N

Consent & Authorization to Release Information

I hereby authorize treatment and the release of any information or photographs acquired in the course of my examination or treatment to my referring doctor or insurance company as necessary. **I understand that I am financially responsible for services and materials provided to me at Pointe Vision Care. If we are unable to collect payment from your insurance company you will be responsible for paying your charges in full.**

SIGNATURE:_____

DATE:_____

Are you interested in contact lenses? Y N

Do You Experience.....

Any discomfort with your eyes?	Y	N
Sensitivity to light?	Y	N
Headaches?	Y	N
Floaters or flashes of light?	Y	N
Double Vision?	Y	N
Itchy/Watery eyes?	Y	N
Blurred Vision?	Y	N
Eye pain?	Y	N

I have read and I understand the privacy policies and have received a copy.

Signature:_____

Date:_____

How did you hear about our office?

_____