VISION BEST EYECARE

Welcome to our office

Today's Date	☐ New Patient ☐ Former Patient ☐ Minor (under age 18)		
Last Name	**First Name**	☐ M ☐ F	**Birth Date** / /
Address	**City**	**State**	**Zip**
Home Phone / **Work Phone**	**Cel Phone**	**E-mail**	
Employer	**Occupation**	**Referred By**	

Insurance Information

Primary Insurance			
Insured Name		**Insured Date of Birth** / /	**Relationship to Patient** ☐ Self ☐ Spouse ☐ Child
Group Number	**Insured SS #**	**Patient SS#**	
Secondary Insurance			
Insured Name		**Insured Date of Birth** / /	**Relationship to Patient** ☐ Self ☐ Spouse ☐ Child
Group Number	**Insured SS #**	**Patient SS#**	

Authorization for Release of Medical Information

I authorize Vision Best Eyecare to release medical information requested by insurance companies with which I may have coverage or any public agency which may be assisting with payment of medical care.

Authorization of Insurance Benefits

I authorize payment benefits, otherwise payable to me, be paid to Vision Best Eyecare/ NB Source, PLLC. I understand that I am fully responsible for all charges not covered by my insurance plan. I authorize refund of overpaid insurance benefits when my coverage is subject to coordination of benefits. In the event of default, I agree to pay all costs of collections. This release of medical information and assignment of benefits is considered in force from the date of signing until revoked in writing.

Acknowledgment of HIPPA Receipt

I acknowledge that I have read Vision Best Eyecare's Notice of Privacy Practices.

Signature	**Date** / /

(Patient's signature or guardian's signature if patient is a minor under age 18)

Yes ☐ **No** ☐
Special Tasks Information

Please check any of the following that you participate in:
☐ Night driving
☐ Fine, detailed work
☐ Extended reading
☐ Computer use: How many hours? ____
☐ Dangerous work environment (Safety Rx)
☐ Play a musical instrument? Which one(s)?
☐ _____

Sun and Sport Information
Do you wear sunglasses outdoors? **Yes** ☐ **No** ☐

Please check any of the following that you participate in:
☐ Outdoor occupation
☐ Golf
☐ Fishing / Boating
☐ Baseball / Softball
☐ Football / Basketball
☐ Running / Biking
☐ Skiing
☐ Other _____

Medical & Eye History

Last Name	First Name	Birth Date / /

Reason for today's exam: _____

Date of last eye exam _____ Age of present glasses _____

List any medication you are currently taking _____

_____

_____

List any allergies to medication _____

_____

_____

List any previous surgical procedures _____

_____

_____

Are you a smoker? Yes ☐ No ☐ **Do you use recreational drugs? Yes ☐ No ☐**

Review of system: Please check any conditions that apply to you or your family.

EYE	Yes	No	Family
Flashes/Floaters	___	___	___
Glaucoma	___	___	___
Macular Degeneration	___	___	___
Retinal Disease	___	___	___
Lazy Eye	___	___	___
Other _____	___	___	___
RESPIRATORY			
Asthma	___	___	___
Emphysema	___	___	___
Bronchitis	___	___	___
VASCULAR			
Diabetes	___	___	___
Hypertension	___	___	___
Heart Disease/Stroke	___	___	___
BONE/JOINT/MUSCLE			
Rheumatoid Arthritis	___	___	___
Joint Pain	___	___	___

ENDOCRINE	Yes	No	Family
Thyroid Disease	___	___	___
Adrenal Problem	___	___	___
ALLERGIES/IMMUNOLOGIC			
Seasonal Allergies	___	___	___
Hay Fever	___	___	___
AIDS	___	___	___
Other _____	___	___	___
PSYCHIATRIC			
Anxiety	___	___	___
Depression	___	___	___

Do you currently wear contact lenses? Yes ☐ No ☐

Have you ever worn contact lenses? Yes ☐ No ☐

Are you interested in new contact lenses? Yes ☐ No ☐

Contact Lens Information: What brand of contacts are you currently using? _____

Do you sleep in your contacts? _____

Do you have any problems with your current contact lenses? _____