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? _____