# Patient Information

**Please fill out this questionnaire at your own convenience and sign the two consent forms at the bottom before submitting it to us online. We will then have the forms on file and ready for your appointment when you arrive.**

## 1. PATIENT INFORMATION

First Name _____ Middle Initial _____ Last Name _____ Preferred Name _____

Date of Birth _____ Social Security _____

Gender
○ Female ○ Male

Marital Status
○ Single ○ Married
○ Divorced
○ Widowed ○ Minor

Race
○ American Indian / Alaska Native ○ Asian ○ Black / African American ○ Hispanic
○ Hawaiian / Pacific Islander ○ White / Caucasian ○ Other

Address _____

Home Phone _____ Work Phone _____ Mobile Phone _____

Your Preferred Method of Contact
○ Telephone ○ Email ○ Postal

How did you hear about us?
☐ Insurance Plan ☐ Family ☐ Friend ☐ Close to home / work
☐ Yellow Pages ☐ Doctor ☐ Other

## 2. PERSON RESPONSIBLE FOR ACCOUNT

First Name _____ Middle Initial _____ Last Name _____

Relationship to Patient _____ Birthdate _____ Social Security Number _____

Phone Number _____ Address (If different than patient) _____

Vision Insurance Co. _____ Vision ID# _____

Subscriber's Name _____ Subscriber's Date of Birth _____

Primary Medical Insurance _____ Secondary Medical Insurance _____

## 3. IN CASE OF EMERGENCY

Person to contact in case of an emergency _____ Relationship _____ Phone Number _____

4. **For your convenience, our office uses e-mail and text messages to confirm appointments and notify you when orders are ready for pickup.**

Your E-mail Address _____

May we share with you any special news via E-mail?
○ Yes ○ No

Would you like to receive text message reminders?
○ Yes ○ No

## 5. EMPLOYMENT

Employment Status
○ Full Time ○ Part Time ○ Student ○ Military ○ Retired ○ Self Employed ○ Not Employed

Employer _____

Occupation _____

## 6. INSURANCE INFORMATION

Who is the Primary Member on your Insurance?
○ Spouse ○ Parent ○ Guardian ○ Self

Insured Member's Name (If not yourself) _____

Insured's DOB _____

Insured Member's Address _____

Insured's SSN _____

Home Phone _____

Work Phone _____

Mobile Phone _____

## 7. LIFESTYLE QUESTIONS

Do you work at a computer?
○ Yes ○ No

What types of prescription glasses do you currently have?
☐ Distance ☐ Reading ☐ Computer
☐ Sunglasses ☐ Sports

What outdoor activities do you participate in?
☐ Boating / Fishing ☐ Hunting
☐ Sports ☐ Other

How many hours per week do you spend outdoors? _____

## 8. CONTACT LENSES

What type of contact lenses do you wear?
○ Soft ○ Toric
○ Rigid Gas Perm
○ Bifocal / Multifocal ○ None

What brand of contacts? _____

Are your contact lenses comfortable?
○ Yes ○ No

Do you sleep in your contact lenses?
○ Yes ○ No

How often do you change your contact lenses?
☐ 1 Day ☐ 2 Weeks ☐ 1 Month
☐ 3 Months ☐ 6 Months

Please list what contact lens solution(s) you use.

_____

Are you interested in wearing contact lenses today?
○ Yes ○ No

Will you be a new contact lens wearer today?
○ Yes ○ No

## 9. PRIMARY CARE PHYSICIAN

Who is your Primary Care Physician?

PCP's Office Name / Location

## 10. MEDICATIONS

Do you have any ALLERGIES to any medications?
○ Yes ○ No

Which drugs are you allergic to?

Please list all medications you take regularly (inlcuding prescription, over-the-counter, vitamins, etc...)

## 11. PERSONAL HEALTH HISTORY Please check any of the following conditions you currently have or have had in the past. Please provide details if applicable.

| | | |
|---|---|---|
| ☐ High Blood Pressure | ☐ Diabetes | ☐ Stroke |
| ☐ Heart Disease / Attack | ☐ High Cholesterol | ☐ Thyroid Condition |
| ☐ Arthritis | ☐ Multiple Sclerosis | ☐ Seizures |
| ☐ Cancer | ☐ Asthma / Emphysema | ☐ Flashes of Light |
| ☐ Blood Disorders / Anemia | ☐ Kidney | ☐ Bone |
| ☐ Prostate Problems | ☐ STDs | ☐ HIV / Hepatitis |
| ☐ Headaches / Migraines | ☐ Retinal Tear / Detachment | ☐ Macular Degeneration |
| ☐ Glaucoma | ☐ Lazy Eye | ☐ Eye Injury |
| ☐ Eye Surgery | ☐ Dry Eye | ☐ Itchy Eyes |
| ☐ ADD/ ADHD | ☐ Pregnant | ☐ Other |

## 12. Height

Weight

## 13. Do you smoke tobacco products?
○ Yes ○ No

How many packs per day?

For how many years?

Do you use recreational drugs?
○ Yes ○ No

Do you drink alcohol?
○ Yes ○ No

14. FAMILY HEALTH HISTORY Has a member of your immediate family been diagnosed with any of the following? Please indicate on the lines below with: "F" for Father, "M" for Mother, "S" for Sister, "B" for Brother, "GF" for Grandfather, and "GM" for Grandmother. For "GF" and "GM" please specify Mother's side (ex: GF-M) or Father's side (ex: GM-F).

| | | |
|---|---|---|
| ☐ Blindness<br>_____ | ☐ Glaucoma<br>_____ | ☐ ARMD (Macular Degeneration)<br>_____ |
| ☐ Eye Turn<br>_____ | ☐ Cataract<br>_____ | ☐ Hypertension<br>_____ |
| ☐ Diabetes<br>_____ | ☐ Cancer<br>_____ | ☐ Cardiovascular Disease (Heart)<br>_____ |

The above information is true to the best of my knowledge. Payment from my insurance is to be paid directly to Southern Vision Care. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company. Final determination can only be made after the claim is processed. I understand that fees for services rendered are non-refundable. My signature below also acknowledges that I have been offered/read Southern Vision Care's "Notice of Privacy Practices". I also understand that I am ultimately responsible for any charges incurred. I agree to be responsible for collection/attorney's fees in the event that my account is sent to collections. I authorize Southern Vision Care or my insurance company to release any information required to process my claims.

_____ _____

Signature Date

_____ _____

Signature Date