PATIENT INFORMATION

M / F Last Name_____ First Name_____ Birth Date_____

If patient is under 18 years old: Mother _____ Father _____

In custody of: [] both parents [] Mother [] Father [] Guardian / Relation_____

Address_____

Cell Phone_____ Secondary Tel: home / work / cell_____

Email_____ Occupation/Grade Level & Employer/School_____

Referred By: [] walk by [] insurance listing [] family []friend [] family doctor [] other_____

Emergency contact: Name_____ relationship_____ Phone #_____

Previous Patient? Y / N ; Date of Last Eye Exam_____ From Dr. _____

History of Glasses Wear: [] Never [] Age of present glasses_____

History of Contacts Wear: [] Never [] Last worn contacts_____

Reason for Today's Visit:
- ▢ Eye problem(s): such as red eyes, itchy eyes, watery eyes, eye pain, seeing spots etc.
- ▢ Vision Problem(s): Need/want new/update glasses and/or contact lenses
- ▢ No problem; Eye wellness check
- ▢ Other_____

Are you planning to get new glasses today? []yes []no []undecided New contacts today? [] yes [] no [] undecided

Do you or any of family members (Grandparents, parents, brothers or sisters) have any of these conditions?

	Self	Family	None		Self	Family	None		Yes	No
Diabetes	[]	[]	[]	Glaucoma	[]	[]	[]	Do you see double?	[]	[]
High Blood Pressure	[]	[]	[]	Cataracts	[]	[]	[]	Frequent headaches?	[]	[]
Thyroid	[]	[]	[]	Retinal Disease	[]	[]	[]	Are you pregnant?	[]	[]
Heart Disease	[]	[]	[]	Eye Surgery	[]	[]	[]	Are you breastfeeding?	[]	[]
Asthma	[]	[]	[]	Eye Injury	[]	[]	[]	Eyes Been dilated	[]	[] year?_____
Cancer	[]	[]	[]	Other	[]	[]	[]	Primary Care Dr._____		

Note for positive findings_____

List of current eye drops (prescription or over the counter): [] None [] List_____

List of current all other medications (prescription or over the counter): [] None []List_____

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Known food or medication allergies: [] None [] List:_____

List any person or entity (spouse, parents, children, or doctor office) that you approve to receive your protected health information and financial information without any further authorization. (let us know if you want more than 2 people)

1)_____ 2)_____
Name Relation Name Relation

By signing below, I acknowledge that
1) I voluntarily consent to any and all eye care treatment and diagnostic procedures by Envue Optometry and its associated doctors and other personnel.
2) I have read, understand, and/or received a copy of the HIPAA disclosure (Notice of Privacy Practice) and Office Policies.
3) I understand that eligibility and benefit provided by the insurance / vision plan are not a guarantee of payment. I authorize ENVUE OPTOMETRY to release any information to process all insurance claims for services rendered. I also authorized payment of benefits directly to this office. I understand that I am responsible for any charge not paid by my insurance / vision plan as well as any deductible and / or co-pays.

Patient / Guardian Signature_____ Date_____

For Office Use Only: Health Insurance (PPO / HMO): [] Anthem []Blue Cross []Blue Shield []Health Net [] kaiser []United Health Care []Other
Vision Plan: []Self Pay []VSP: sig - choice - value - essen []EyeMed []MCal: reg - VSP - March - Envolve []Davis []Spectera [] other_____
Insured Name_____ Relationship to patient: [] self [] spouse [] parent [Insured
DOB_____ Last 4 SS#_____ ID #_____