20/20 VISION LLC
FOCUSED ON YOU
OPTOMETRY

PATIENT INFORMATION

Thank you for choosing our office! In order to serve you properly, we need the following information. **Please print!**

All information will be confidential.

How did you hear about us? ☐ Insurance Referral ☐ Yellow Pages/Newspaper ☐ Lola's List ☐ K-Love Radio

☐ Doctor Referral_____ ☐ Patient Referral: _____ ☐ Other _____

Patient Name: _____

(First) **(MI)** **(Last)** **Date**

Reason For Visit: ☐ Routine Exam ☐ Glasses ☐ Contacts ☐ Other_____

Social Security Number _____-_____-_____ ☐ Male ☐ Female Birth Date: _____

Home Phone: _____ Daytime/Cell phone: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

E-Mail address: _____

Is Patient (check all that apply): ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Unemployed ☐ Retired ☐ Employed: ☐ Full-time ☐ Part-time Student: ☐ Full-time ☐ Part-time

Patient's or parent's employer: _____ Occupation:_____

Work phone: _____ Business address: _____ City: _____ State: ____ Zip: _____

Spouse or parents' name: _____ Employer: _____

Occupation: _____ Work phone: _____

If patient is a student, name of school/college: _____ City: _____St: _____

Person to contact in case of emergency: _____ Phone: _____

Person Responsible for Account

- **Although our office ensures that we optimize your insurance benefits, we are not responsible for what your insurance covers and does not cover.**

Name of person responsible for this account: _____Relationship to patient: _____

Is this person currently a patient in our office? ☐ Yes ☐ No Home ph: _____ Day/cell ph: _____

Social Security Number _____-_____-_____ ☐ Male ☐ Female Birth date: _____

Employer: _____ Work phone: _____

All payments are due on the same day services are rendered. Guarantor signature: _____

AUTHORIZATION & RELEASE: I authorize the release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

Signature: _____ Date: _____ (Please turn over & complete the other side)

Circle all that apply:

I currently wear: Glasses Contacts Both

I am currently experiencing:	**I have trouble with:**	**Ocular Symptoms:**	**I have or have had:**
Dry eyes	Distance (Long range)	Eye Fatigue	Glaucoma
Visual Headaches	Reading (Near Vision)	Pain	Macular degeneration
Ocular fatigue	Computer (Mid range)	Pressure feeling	Cataracts
Squinting	**Trouble experienced:**	Burning	Amblyopia (lazy eye)
Poor depth perception	With glasses/contacts on? Yes / No	Sandy or gritty	Strabismus (eye turn)
Halos			

List all **EYE** surgeries you have had: _____ Date of surgery(s): _____

Review of Systems: Please indicate if you currently experience or have ever experienced any of the following:
All the following information relates to your vision and eye health. **This information is kept strictly confidential**.

Constitutional Symptoms:
Recent Fever..... No Yes
Recent Fatigue..... No Yes

Ear/Nose/Throat/Mouth:
Hearing Loss..... No Yes
Nose Bleeds..... No Yes
Sore Throat..... No Yes
Mouth Sores..... No Yes
Sinusitis.... No Yes

Neurological:
Headaches..... No Yes
Head or neck injury No Yes
Paralysis..... No Yes
Fainting ..... No Yes
Seizure Disorder... No Yes
Tremors..... No Yes
Numbness/Tingling
Sensation.....No Yes

Endocrine:
Diabetes..... No Yes
Thyroid Problems... No Yes

Respiratory:
Shortness Of Breath No Yes
Wheezing..... No Yes
Spitting Up Blood No Yes
Asthma... No Yes
COPD.... No Yes
Bronchitis.... No Yes

Gastrointestinal:
Loss of appetite.... No Yes
Nausea and Vomiting No Yes

Psychiatric/Mental:
Memory loss or
Confusion..... No Yes
Depression..... No Yes
Other psychiatric
Problems..... No Yes

Cardiovascular/Heart:
High blood pressure No Yes
High cholesterol.... No Yes
Heart Attack or
Disease..... No Yes
Chest pain..... No Yes
Stroke..... No Yes
Swollen feet, ankles
Or hands..... No Yes

Integumentary/Skin:
Skin problems:_____

Genitourinary/Bladder:
Genital/urinary or
Bladder problems.. No Yes

Hematologic/Lymphatic:
Anemia..... No Yes
Bleeding or
Bruising tendency.. No Yes
Slow to heal
After cut..... No Yes

Musculoskeletal:
Joint stiffness or
Swelling..... No Yes
Muscle pain or
Cramps..... No Yes
Back Pain..... No Yes
Cold extremities.. No Yes

Allergic/Immunologic
Pollens..... No Yes
Penicillin or
Other antibiotics.. No Yes
Vicodin or
Other narcotics.. No Yes
Novocain or
Other anesthetics.. No Yes
List allergies to drugs:_____
_____

Other health problems:_____ Are you pregnant or nursing? ☐ Yes ☐ No
Medical Doctor:_____ Date of last eye examination:_____Location:_____
Previous hospitalizations and surgeries:_____
Medications: (Include Non-Prescription, vitamins, and eye drops):_____

Family Medical History	Age	Medical/Eye Diseases	If Deceased, Cause of Death
Father	___	_____	_____
Mother	___	_____	_____
Siblings	___	_____	_____
Spouse	___	_____	_____

Do you drive? ☐ Yes ☐ No If yes, do you have difficulty when driving? ☐Yes ☐No If yes, please describe:_____

Have you ever been exposed to or infected with: ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis

Use of Alcohol: ☐Never ☐Rarely ☐Moderately ☐ Daily

Use of Tobacco: ☐Never ☐Previously, but not in the past_____year(s) ☐Currently, and _____ packs/day

Other substances (prescribed or unprescribed):_____

20/20 VISION OPTOMETRY