

Welcome to Integrity Vision Care

PATIENT INFORMATION

Patient's Last Name:		First:	MI:	Nickname:	
Home Address:			City, ST Zip:		
Phone: (check preferred)					
<input type="checkbox"/> Hm:		<input type="checkbox"/> Cell:		<input type="checkbox"/> Wk:	
Email Address:		DOB:	Sex:	Marital Status:	
			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other	
SS#:	Employer/School:		Occupation/Grade:		
Billing Address (if different):					
Why did you choose our office?					
<input type="checkbox"/> Website <input type="checkbox"/> Location <input type="checkbox"/> Ins. Plan <input type="checkbox"/> Other <input type="checkbox"/> Referred by:					
Parents/guardians if patient is a minor			Other family members seen at this office:		
Race:					
<input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Native American/Alaskan <input type="checkbox"/> White <input type="checkbox"/> Decline					
Ethnicity:			Preferred Language:		
<input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Decline			<input type="checkbox"/> English <input type="checkbox"/> Spanish		

INSURANCE INFORMATION

<p>Please note: Most "Vision" plans only cover refractions and routine, non-medical eye exams. Visits involving medical problems such as conjunctivitis, dry eye, ocular injuries, cataracts, glaucoma, macular degeneration, sudden pain or vision loss or monitoring for ocular side effects of chronic diseases such as diabetes and hypertension fall under your medical insurance coverage, not your "vision" plan. Some Well Vision Plans will apply your benefits toward medical co-pay and deductibles and some do not. If you have any questions about your coverage, be sure to contact your insurance company before your scheduled appointment.</p>					
Medical Insurance Carrier:		ID#	Policy/Group #		
If the patient is NOT the insured, please fill out the following information for the INSURED:					
Name:		DOB:	SS #:	Patient's relation to insured:	
				<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	
Address (if different):				Phone:	
Vision Plan:		ID#:	Policy/Group #:		
If the patient is NOT the insured, please fill out the following information for the INSURED:					
Name:		DOB:	SS #:	Patient's relation to the insured:	
				<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	
Address (if different):				Phone:	

General Medical History

Primary Physician		Physician's Phone number		When was your last physical exam?	
Check the box for any conditions that apply:					
	You	Mom	Dad	Sib	Describe
Hypertension					
Thyroid disease					
Cardiovascular disease					
Cancer					
Diabetes					
If YOU are diabetic, when were you diagnosed?				What was your last A1c level?	
Check if applicable:		Do you live alone?			
<input type="checkbox"/> I am pregnant <input type="checkbox"/> I am nursing		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Assisted Living <input type="checkbox"/> Nursing Home			
Smoking history:			Alcohol use:		
<input type="checkbox"/> Never <input type="checkbox"/> Former smoker <input type="checkbox"/> Some days <input type="checkbox"/> Every day			<input type="checkbox"/> None <input type="checkbox"/> Occasional <input type="checkbox"/> Social <input type="checkbox"/> 1drink/day <input type="checkbox"/> 2+drinks/day		
Current Weight:			Current Height:		
List ALL major injuries or surgeries you have had and approx dates:					
List any other medical conditions you have, including non-drug allergies:					
List all Rx and over-the-counter medications you currently take:					
List any vitamins or supplements you currently take:					
List any drug allergies you have					

Review of Systems – List any problems you are currently having anywhere, from head to toe:

General (e.g., fever, fatigue, loss of appetite, unexplained weight loss/gain)
Ear, Nose, Throat (e.g., sinus/nasal congestion, nose bleeds, dry mouth/throat, sleep apnea, hearing problems)
Cardiovascular (e.g., chest pain, racing heartbeat, swollen feet/ankles, TIAs)
Respiratory (e.g., chronic cough, shortness of breath, wheezing)
Genital, Kidney, Bladder (e.g., bladder/urinary problems, pain, discharge, menstrual changes, impotence)
Gastrointestinal (e.g., constipation, diarrhea, gastric reflux (GERD), jaundice, nausea, vomiting)
Endocrine (e.g., heat or cold intolerance, thinning hair, excess thirst, excess urination)
Muscles, Bones, Joints (e.g., pain, stiffness, swelling, weakness, limited movements)
Skin (e.g., dry, itchy, flaky, rash, growths, bumps, redness, discoloration)
Neurological (e.g., headaches, numbness/tingling, tremors, poor balance, dementia, speech problems)
Psychiatric (e.g., depression, anxiety, sleep problems, paranoia, obsessive/compulsive)
Blood/Lymph (e.g., anemia, bleeding gums, delayed clotting, unexplained bruising)
Allergy/Immune (e.g., swollen lymph nodes, itching, sneezing, runny nose/eyes)

Who was your previous eye doctor?				When was your last eye exam?	
Check any conditions that apply:					
	You	Mom	Dad	Sib	Describe
Glaucoma					
Macular Degeneration					
Retinal problems					
Cataracts					
Lazy eye/Eye turn					
List major EYE injuries, infections or surgeries and approx dates					
List any other eye problems you have had in the past					
List any EYE drops you use (Rx or OTC)					
List any vision complaints you are having such as: <ul style="list-style-type: none"> • blurred vision, headaches, eyestrain, double vision or losing your place when reading; • itching, burning, redness, sensitivity to light, watering, crusting or mucus discharge; • seeing dark spots, squiggles or webs, bright flashes or colored rainbows around lights at night. 					
How many hours/day do you typically spend using a computer or other digital devices?					
If you're having complaints with computer work, how far is the monitor from your eyes?					
How many hours/day do you typically spend reading books, magazines, etc?					
What are your hobbies?					
Do you currently wear glasses?		If yes, please choose purpose: <input type="checkbox"/> Distance <input type="checkbox"/> Reading <input type="checkbox"/> Both			
Do you have sunglasses?	Do you have back-up glasses?	Are you interested in contact lenses?			
What are your goals for contact lens wear?		Have you had problems with contacts in the past?			

Contact Lens Wearers Only

What disinfecting solution do you use?	
How long do you wear your contact lenses?	
How often do you replace your contact lenses?	When you replace them, are the new lenses noticeably clearer or more comfortable?
How old is your current pair of contact lenses?	