## **Welcome to Precision Eyecare Centers!**

$\square$ Dr. $\square$ Mr. $\square$ Mrs. $\square$ Ms.	∃ Ms.		Date:	
First Name:	Last Name:	Nickname	Birthdate	Age
Address:	City _		Zip	_ □Male □Female
Home Phone:	Cell Phone	Email		
Occupation:				
How did you hear about us? ☐Insu				
		•		
Vision Insurance  None	□VSP □Eyemed □Davis	□Other	Member ID	
Subscriber □Self □Spouse/Pare				
Medical Insurance  None				
medical ilisulative — Inone	- Office Treatment - Orgina	_Raisci of Fillio		
<ol> <li>Authorization of Payment</li> <li>I authorize the release of medical information necessary to process my insurance claims. I authorize payments to be made directly to my doctor. I understand that I am responsible for any charges not covered by my insurance.</li> <li>Notice of Privacy Practices</li> <li>I received, understand, and consent to the terms set forth in the Notice of Privacy Practices for Precision Eyecare Centers.</li> <li>Request for Electronic Communications</li> <li>I allow the following methods of communication from Precision Eyecare Centers in regards to appointments, results, reminders or notification of eyewear received. I understand these methods may not be secure, and I accept the risks for receipt by unauthorized individuals. (Mark all that apply:)</li> <li>□ Phone call □ Voicemail □ Messages with whomever answers phone □ Text messages □ Email</li> </ol>				
I hereby acknowledge statements 1		 tative Signature R	elationship to Patient (if chil	_ <del></del> d) Date
	Fallent / Represent	lative Signature R	elationship to Fatient (il chii	u) Date
Health History			C PL P	
Last eye exam years			ast dilation years	
Medications (prescription, over-the-counter, eye drops):   None				
Allergies:   Environmental/ Hay Fever   Allergies to medication:   Other allergies   None				
Are you pregnant or breastfeeding?	□Yes □No			
5				
Please mark all that apply:	10	<b></b>	11: 1	5 . <i></i>
Visual & Ocular Symptoms		i -	History Self	
□None, routine eye exam	Cataracts   Glaucoma		s* $\square$ od pressure $\square$	
☐Glasses / Contacts blurry ☐ Distance ☐ Near				
□ Eye strain □ Dryness	Macular Degeneration ☐ Strabisumus (Eye Turn) ☐	; •	olesterol ⊔ disorder □	
☐ Headache ☐ Burning				
□Double vision □Watering	Amblyopia (Lazy Eye) □ Retinal detachment / tear □			
□ Light sensitivity □ Itching		U Other		
☐ Floaters ☐ Eye pain	Eye trauma or injury	: -		
	Eye surgery:  Other:	□ * If diabe	tic, list doctor's name	
		□ II diabe	tio, fist doctor's flame	
<del></del>				
☐ Cardiovascular ☐ Constitutiona			ointestinal □Genitourir	· ·
☐ Hematological ☐ Immunologic	J ,	culoskeletal □Neuro	•	Respiratory
□Major injuries/surgeries. If any checked, please explain				
Glasses Age of current pair yrs Use: □Full Time □Distance □Computer/Reading □Sun □Lost/Broken □None				
Contact Lenses ☐ Never used ☐ In the past, not anymore ☐ Interested in trying contacts today				
Current:   Most of the time  Few times a week  Occasional  Average hours of wear per day				
Are you happy with your contacts?   Yes   No, because				
Social History Do you drink alcohol?	□ No □ Yes:	=	drinks per day □ 3+ c	
Do you use tobacco products? ☐ Never ☐ Former smoker ☐ Current smoker: <i>Type</i>				
How much/often? # yrs				
Do you use recreational drugs?	□ No □ Yes:	□ Narcotics □ Oth	er type	
Exposure to any infectious diseases?				