Virginia Beach Family Eyecare P.C.

Patient Name _____ DOB _____ Todays Date _____

Address_____ City_____State____ Zip_____

Email_____

SSN _____ Home Phone _____ Cell Phone _____

Name of person responsible for insurance (if it's not you) _____ DOB _____

Relationship to patient_____ Phone_____ SSN(Tricare only)_____

CONFIDENTIAL HEALTH HISTORY

Date of last eye examination _____Where? _____

What is the reason for your visit today? *(Circle all that apply)*
Rx for glasses, Rx for contact lenses, Other Eye Health Concern:
_____

Do YOU have any of the following conditions? (Circle all that apply)

High Blood Pressure, High Cholesterol, Diabetes Type 1, Diabetes Type 2, Heart Disease, Hyper/Hypothyroid, History of Cancer, Cataracts, Glaucoma, "lazy eye", History of Eye Injury, or Surgery, Macular Degeneration, Pregnant / Nursing, other: _____

Is there FAMILY HISTORY of any of these? (Circle all that apply)

High Blood Pressure, High Cholesterol, Diabetes Type 1, Diabetes Type 2, Heart Disease, Hyper/Hypothyroid, History of Cancer, Cataracts, Glaucoma, "lazy eye", History of Eye Injury, or Surgery, Macular Degeneration, other: _____

Please list all medications you are currently taking:
_____
Do you have an ALLERGY to any medications? None (that I know of) or yes, (please list)
_____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if **I,** or my minor child, ever have a change in health. Also, if using Insurance, any service not covered by insurance is patient's responsibility. I have read and understand this form, and I am signing it voluntarily. I hereby authorize the professional office named above to release health information identifying me. **I agree all payments due upon service provided are not refundable**. **If you are signing this as a personal representative of the patient, describe your relationship to the patient and the source of authority to sign this form:**

Signature: _____