

Welcome to CLEAR VISION OPTOMETRY

Patient Information (Please write clearly)

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Gender \_\_\_\_\_

Home# \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Address \_\_\_\_\_
Street, City, ZIP

email address \_\_\_\_\_

Under 18? \_\_\_\_\_ If Yes, name of legal guardian \_\_\_\_\_

Please answer following questions completely to your best knowledge.

- Do you have any allergy to medicine? No Yes
Do you have any environmental allergy (hayfever, etc)? No Yes
Do you have a special vision need for your hobby or work? No Yes
Have you had any eye surgery? No Yes
Have you had any eye injury? No Yes
Have you had sight-threatening eye infection? No Yes
Have you had any eye therapy? No Yes
Have you had any severe head injury? No Yes

Please list name of medication you take regularly including herbal, dietary supplements.

Body None at this time \_\_\_\_\_
Eye None at this time \_\_\_\_\_

Mark if YOU or any of your immediate (PARENTS, SIBLINGS, AND GRANDPARENTS) family has any of following conditions.

Table with 5 columns: NONE AT THIS TIME, High blood pressure, Thyroid problem, Kidney disease, Asthma, Eye disease, High cholesterol, Seizure/ Epilepsy, Liver disease, Chronic sinus problem, Lazy/Crossed eye, Heart problem, Mental condition, Infectious disease, Rheumatoid arthritis, Diabetes, Stroke, Lupus, Cancer, Pregnancy (Mark if applies to you)

OTHER MEDICAL CONDITION THAT IS NOT LISTED

Do you use tobacco products? No Yes If Yes, for how many years? \_\_\_\_\_ How much? \_\_\_\_\_
Do you drink alcoholic beverage? No Yes If Yes, how often? \_\_\_\_\_ How much? \_\_\_\_\_

I certify that I have accurately answered the above questions to the best of my knowledge. I understand that providing incorrect information can be dangerous to my or my dependent's health. I authorize CLEAR VISION OPTOMETRY™ to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such eye care to third party payor and/or health practitioners. I authorize and request my insurance company to pay directly to CLEAR VISION OPTOMETRY™. I understand that my eye care insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Initial \_\_\_\_\_ I have been presented with Clear Vision Optometry's Notice of Privacy Practices. I have read and understood the notice.

Signature of Patient or Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_