ReVision EYE CARE LLC

Patient Information----------

Date:_____ Name: _____ Birthdate:_____

Preferred Name (i.e. Bob vs. Robert)_____ Parent or Guardian (if Applicable):_____

Address:_____ City:_____ State:_____ Zipcode:_____

Home Phone: _____ Cell Phone:_____

Work Phone: _____ E-mail:_____

Date of last eye exam:_____ Where:_____

Primary Care Physician:_____

Employer:_____ Occupation: _____

School Attending:_____ Grade Level: _____

Hobbies:_____

Current Corrective Lenses: □ Glasses □ Contacts □ Other

In case of emergency, contact: _____

Relationship:_____ Phone:_____

Gender: Male Female

Race/Ethnicity:

□White (Not Hispanic)

□Hispanic/Latino □Asian

□African American/Black

□American Indian □ Other

Marital Status:

□ Single □ Married □ Divorced

□ Widowed □ Other

Chief Complaint /Reason for Visit: Check all that apply

□General Exam □RX for Glasses □RX for Contacts □Loss of Vision □Blurred Vision □Double Vision

□Watery Eyes □Itchy Eyes □Gritty/Sandy Eyes □Something in Eye □Dry Eyes □Floaters □Light Sensitivity

□Other_____

Follow Up On: □ Glaucoma □Cataracts □Macular Degeneration □Diabetes □Eye Surgery □Other

PRIMARY INSURANCE----------

Health Insurance:_____ ID#_____ Group#_____

Vision Insurance: _____ ID#_____ Group#_____

Subscriber's Information: Name: _____ Birthdate:_____ Male / Female

Employer:_____ Subscriber's SSN:_____

Relationship to Patient: □Self □ Spouse □ Parent □ Other_____

SECONDARY INSURANCE ----------

Health Insurance: _____ ID#_____ Group#_____

Vision Insurance: _____ ID#_____ Group#_____

- I authorize the release of any medical information necessary to provide the most beneficial examination and I can revoke with a written request.
- ReVision Eye Care will submit insurance claims with the insurance information given by the patient at the date of service. I understand ReVision Eye Care LLC is not accepting new Forward Health accounts. I am responsible for all charges regardless of insurance benefits.
- I acknowledge that I have received a copy of the Notice of Privacy Practices (HIPPA Compliance).

Patient / Guardian Signature: _____ Date:_____

Please turn form over and enter health history information →→→→

Health History: check all boxes that currently apply

Eyes
- ☐ Glaucoma
- ☐ Cataract
- ☐ Macular degeneration
- ☐ Surgery
- ☐ Blurred vision
- ☐ None

Gastrointestinal
- ☐ Crohn's disease
- ☐ Gastric reflux
- ☐ Ulcerative colitis
- ☐ Ulcer
- ☐ None

Psychiatric
- ☐ Anxiety
- ☐ Bi-polar disorder
- ☐ Depression
- ☐ Schizophrenia
- ☐ Panic disorder
- ☐ None

Constitutional
- ☐ Developmental disability
- ☐ Weight loss
- ☐ Fever
- ☐ Fatigue
- ☐ Trauma
- ☐ None

Genitourinary
- ☐ Prostate enlargement
- ☐ STD, Herpes, Chlamydia
- ☐ None

Endocrine
- ☐ Type 1 diabetes
- ☐ Type 2 diabetes
- ☐ Diabetes - borderline
- ☐ Diabetes - gestational
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ None

Cardiovascular
- ☐ Heart disease
- ☐ High cholesterol
- ☐ High blood pressure
- ☐ Stroke
- ☐ Vascular disease
- ☐ None

Musculoskeletal
- ☐ Ankylosing spondylitis
- ☐ Fibromyalgia
- ☐ Muscular dystrophy
- ☐ Osteoarthritis
- ☐ None

Blood/Lymphatic
- ☐ Anemia
- ☐ HIV/Aids
- ☐ Leukemia
- ☐ None

Ear, Nose, Mouth & Throat
- ☐ Respiratory tract infection
- ☐ Ear ache
- ☐ Runny nose
- ☐ Sore throat
- ☐ None

Integumentary
- ☐ Eczema
- ☐ Rosacea
- ☐ Psoriasis
- ☐ None

Allergic/Immunologic
- ☐ Sjogren's syndrome
- ☐ Systemic lupus erythematosus
- ☐ Rheumatoid arthritis
- ☐ None

Respiratory
- ☐ Current smoker
- ☐ Previous smoker
- ☐ Never smoked
- ☐ Asthma
- ☐ Bronchitis
- ☐ COPD
- ☐ Emphysema

Neurological
- ☐ Alzheimer's
- ☐ Cerebrovascular
- ☐ Dementia
- ☐ Epilepsy
- ☐ Involuntary movement
- ☐ Multiple sclerosis
- ☐ Parkinson's
- ☐ None

Please list additional health conditions not listed:

Allergies: list all allergies, including medications, and environmental

Medications: list name, dose and number of times taken per day. If not medications are taken, please write "none".

Family Health History: check and note family relationship

- ☐ Amblyopia
- ☐ Blindness
- ☐ Cataracts
- ☐ Macular degeneration
- ☐ Glaucoma
- ☐ Retinal disease
- ☐ Lazy eye
- ☐ Arthritis
- ☐ Cancer
- ☐ Diabetes
- ☐ Heart disease
- ☐ Stroke
- ☐ High cholesterol
- ☐ Cardiovascular disease
- ☐ High blood pressure