# ClearVision Centers

PERSONAL IMFORMATION (Please Print)

Name_____ Date_____
Date of Birth_____ Age_____ M / F___ Soc Security_____
Address_____
Street City State Zip
Home Phone: _____ Cell Phone: _____
E-Mail Address _____ Employer_____
Address_____ Phone_____
Marital Status: (please circle one) Single Married Widowed Divorced
Spouse Name_____ Employer_____
Address_____ Phone (___)_____

COMPLETE IF UNDER 18 YEARS OR A STUDENT

Name of Father_____ Employer_____
Address_____ Phone (____)_____
Name of Mother_____ Employer_____
Address_____ Phone (____)_____
Referred by: ___Friend / Relative_____ Doctor _____
Name Name
___Yellow Pages ___Television ___Newspaper ___ Other_____

INSURANCE INFORMATION

Primary Insurance Company Name_____
I.D. Number _____ Group Number_____
Insured Name _____ Insured D.O.B. _____
Relationship _____ Insurance Company Phone _____
Insurance Company Address _____

☐ Secondary Insurance Name _____
☐ Vision Insurance Coverage (VSP / Eyemed / Davis Vision ) _____
I.D. Number _____ Group Number_____
Insured Name_____ Insured D.O.B. _____
Insurance Company Address _____

WHO TO NOTIFY IN AN EMERGENCY (nearest relative or friend)?

Name_____ Relationship_____
Address_____
Street City State Zip
Home Phone (_____)_____ Work / Cell Phone (_____)_____

FINANCIAL ASSIGNMENT AND AGREEMENT:

1. Insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance, and/or any other balance not paid for by your insurance.**
2. I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration, its agents, or any insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services.

Signature (Patient or Parent if minor)_____ Date_____

# Patient Medical History — ClearVision Centers

PRIMARY CARE PHYSICIAN_____

**Please answer the following questions about your medical status and history:**

1. Have you ever been treated for any medical conditions (e.g., diabetes, high blood pressure, arthritis, etc) ?
   Yes___ No___ If YES, please explain:_____

2. Have you ever had any eye disease (e.g, glaucoma, cataract, wandering or "lazy" eye, retinal detachment) ?
   Yes___ No___ If YES, please explain:_____

3. Have you ever had any surgery?
   Yes___ No___ if YES, please provide date and reason_____

4. Have you ever been hospitalized?
   Yes___ No___ If YES, please provide date and reason_____

5. Do you take any medications?
   Yes___ No___ If YES, please list:_____
   Do you take any eye medications?
   Yes___ No___ If YES, please list:_____

6. Do you have any drug or food allergies?
   Yes___ No___ If YES, please list:_____

| **Review of Systems** Do you currently have any of the following problems? | Yes | No | If YES, please explain |
|---|---|---|---|
| Chronic Fever, unexpected weight loss / gain, fatigue……. | ☐ | ☐ | _____ |
| Ear / nose / throat problems (e.g., hearing loss, sinus problems, sore throat)….. | ☐ | ☐ | _____ |
| Heart problems (e.g., chest pain, irregular heart beat)……... | ☐ | ☐ | _____ |
| Respiratory problems (e.g., shortness of breath, wheezing, coughing)…… | ☐ | ☐ | _____ |
| Gastrointestinal problems (e.g., heartburn, abdominal pain, diarrhea, vomiting).. | ☐ | ☐ | _____ |
| Urinal problems (e.g., pain, discomfort, blood in urine)…… | ☐ | ☐ | _____ |
| Skin Problems (e.g., rashes, excessive dryness)……... | ☐ | ☐ | _____ |
| Musculoskeletal problems (e.g., muscle aches, joint pain, swollen joints)…….. | ☐ | ☐ | _____ |
| Neurologic problems (e.g., numbness, weakness, headaches, paralysis)…….. | ☐ | ☐ | _____ |
| Psychiatric problems (e.g., depression, anxiety)……. | ☐ | ☐ | _____ |

Family and Social History

Do any medical or eye diseases run in your family (e.g., diabetes, high blood pressure, cancer, glaucoma, macular degeneration) ? Yes___ No___ If YES, please explain:_____

_____

Do you smoke? If Yes, how much?_____ Drink Alcohol? If Yes, how much_____

If employed, how many hours per week do you work? _____

Comments_____

_____

Signature_____ Date_____