Screening Photo:
☐ Yes ☐ No

Patient Information Form

Please complete and return this form as soon as possible

Appointment Time:

First Name | **Mid.** | **Last Name** | **Preferred Name** | **Birth Date**

Street Address | **City** | **State** | **Zip Code**

SSN | **Marital Status** | **Sex** | **Email Address**

We respect your privacy, and any contact information given to the office will never be shared. We may contact you for Appointments, Order Status, and occasional Marketing Communications.

Home Phone | **Cell Phone** | **Contact Methods**

Home	Cell	Work	TXT	Email
Y / N	Y / N	Y / N	Y / N	Y / N

Employer | **Work Phone** | **Occupation**

Person Responsible for Charges (if not patient) | **Relationship to Patient** | **Phone Number**

First Visit? | **Referred By** (Patient Name, Phone Book, Internet, Insurance Listing, etc...)

Y / N

Race (circle your answer)

American Indian or Alaska Native | Asian | Black or African American | Native Hawaiian or Other Pacific Islander | White | Other Race

Ethnicity

Hispanic or Latino | Not Hispanic or Latino

Pref.Language

Primary Insurance Company | **Insured First Name** | **Insured Last Name**

Insured Identification Number | **Insured Date of Birth** | **Pat. Relation to Insured**

Secondary Insurance Company | **Insured First Name** | **Insured Last Name**

Insured Identification Number | **Insured Date of Birth** | **Pat. Relation to Insured**

Primary Medical Doctor | **Doctor's Phone #** | **Practice Location**

Reason For Today's Visit

General Health - Patient (check all that apply)

- ☐ Allergies / Hay fever
- ☐ Asthma / Respiratory
- ☐ Blood Disorders
- ☐ Cancer
- ☐ Cardiovascular / High B.P.
- ☐ Chronic Bronchitis/Cough
- ☐ Diabetes
- ☐ Emphysema
- ☐ Gastrointestinal Problems
- ☐ Heart Attack / Stroke
- ☐ Headaches / Migraines
- ☐ Kidney Disease
- ☐ Pregnant
- ☐ Psychiatric / Depression
- ☐ Rheumatoid Arthritis
- ☐ Thyroid / Endocrine Disease
- ☐ Skin Disorders
- ☐ Weight Loss / Gain

Family Health History (circle all that apply)

☐ **Unknown For All**

Cancer

Father	N/A	Unknown	Yes	No
Mother	N/A	Unknown	Yes	No
Brother	N/A	Unknown	Yes	No
Sister	N/A	Unknown	Yes	No
Son	N/A	Unknown	Yes	No
Daughter	N/A	Unknown	Yes	No

Diabetes

Father	N/A	Unknown	Yes	No
Mother	N/A	Unknown	Yes	No
Brother	N/A	Unknown	Yes	No
Sister	N/A	Unknown	Yes	No
Son	N/A	Unknown	Yes	No
Daughter	N/A	Unknown	Yes	No

Hypertension

Father	N/A	Unknown	Yes	No
Mother	N/A	Unknown	Yes	No
Brother	N/A	Unknown	Yes	No
Sister	N/A	Unknown	Yes	No
Son	N/A	Unknown	Yes	No
Daughter	N/A	Unknown	Yes	No

Cataracts

Father	N/A	Unknown	Yes	No
Mother	N/A	Unknown	Yes	No
Brother	N/A	Unknown	Yes	No
Sister	N/A	Unknown	Yes	No
Son	N/A	Unknown	Yes	No
Daughter	N/A	Unknown	Yes	No

Macular Disease (Degeneration)

Father	N/A	Unknown	Yes	No
Mother	N/A	Unknown	Yes	No
Brother	N/A	Unknown	Yes	No
Sister	N/A	Unknown	Yes	No
Son	N/A	Unknown	Yes	No
Daughter	N/A	Unknown	Yes	No

Glaucoma

Father	N/A	Unknown	Yes	No
Mother	N/A	Unknown	Yes	No
Brother	N/A	Unknown	Yes	No
Sister	N/A	Unknown	Yes	No
Son	N/A	Unknown	Yes	No
Daughter	N/A	Unknown	Yes	No

Current Medications and Condition Being Treated

☐ **No Current Medications**

Medication	Condition	Medication	Condition

Allergies - Medicinal and Environmental

☐ **No Known Allergies**

Medicinal Allergy	Allergic Response	Environmental Allergy	Allergic Response

Smoking Status: (circle your answer)

Never Smoked Former Smoker Unknown
Current Smoker - Daily Current Smoker - Occasional

Alcohol Use:

Y / N **Every** Day Week Month

Do You Currently Wear Glasses? Y / N Since:

Type Full-time Part-time Distance Close

Glasses Owned (circle all that apply) Single Vision Bifocals Trifocals Backup Safety Sports Progressive

Do You Use a Computer? Y / N Hrs / Day:

Do You Drive? Y / N

Do You Have Problems With Night Vision? Y / N Glare Depth Perception Other (write below)

Do You Wear Sunglasses? Yes ☐ No ☐ **Are Your Sunglasses Your Prescription?** Yes ☐ No ☐

Contacts Lens Use Y / N Since:

Hours / Day

Type and Brand of Contacts

How often do you replace your contacts?

How often do you sleep in your contacts?

If not a contact lens wearer, are you interested in trying contact lenses at this time? ☐ Yes ☐ No

Hobbies / Interests

Please Read:

In order to control the cost of billing, we ask that the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. We would rather control billing costs than be forced to raise our fees. All professional services and materials are charged to the patient. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days are subject to collection fees. There will be a service charge on all returned checks.

Payment from my insurance is to be paid directly to ClearVision Eye Centers. I understand that the insurance listed above as "Primary Insurance" will be billed as my primary insurance. I understand that billing any secondary insurance is my responsibility. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed.

Signature _____ Date _____

Printed Name _____

Acknowledgement of Receipt of Notice of Privacy Practices

By signing this form you acknowledge receipt of the Notice of Privacy Practices for ClearVision Eye Centers Clark County LLP. Our Notice of Privacy Practices provides information about how we may use and disclose your protected information. We encourage you to read it in full.

Our Notice of Privacy Practices is subject to change.

Signature _____ Date _____