Patient Intake Form

Spectrum Vision

First Name: _____ **Last Name:** _____ **Middle Initial:** _____ **Date of Birth:** _____

Street Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Preferred phone number: _____ **Email:** _____ **Gender:** _____

Primary Vision Benefit Plan _____ **Primary Medical Insurance** _____ **Secondary Medical Insurance** _____

Do you wear glasses, contact lenses, or neither? (please circle all that apply)

How did you learn about our practice or whom may we thank for referring you?
(Leave blank if you have been with us before)

_____

Reason for today's visit:

_____

Primary Care Physician: _____ **Date of Last Visit:** _____

Preferred Pharmacy: _____ **Address:** _____

Lifestyle:

Occupation:_____ **Hobbies:**_____
Do you smoke?(Circle one) **Do you drink alcohol? (Circle one)**
Yes or NO **Yes or No**

Check if you have or have had any of the following: (circle all that apply)

Diabetes	**High blood pressure**	**Heart problems**	**Headaches**
Asthma	**Rheumatism, Lupus**	**Arthritis**	**Cancer**
Respiratory disease	**STD**	**Thyroid problems**	**Tuberculosis**
other_____			

Check if you have or have had any of the following vision/eye problems: (circle all that apply)

Glaucoma	**Diabetic Retinopathy**	**Retinal Detachment**	**Cataract**	**Eyestrain**
Dry eye	**Uveitis/Iritis**	**Color Blindness**	**Lazy eye**	**Macular Degeneration**
Keratoconus	**Strabismus**	**Floaters**	**Flashes of light**	**Other_____**

Please list all eye surgeries and their dates below:

_____
_____
_____

Please list any allergies you may have:

_____
_____
_____

List all medications you are currently taking and the reason for taking:

_____
_____
_____
_____

HIPAA

Under the Health Information and Portability and Accountability Act (HIPAA) "individually identifiable health information" may be disclosed only with written permission to anyone other than the patient. All discussions about a patient's medical condition must be kept in a private setting. All medical records are to be accessed on an as needed basis.

Please sign below to indicate you have been offered a copy of Spectrum Vision's complete revised privacy policy.

Name:_____

Signature:_____**Date:**_____