Today's Date:_____/_____/_____

Patient's Name: First _________________________ Middle initial_______ Last_______________________________

Permanent Address______________________________________City_________________State____ZIP___________

Date of Birth_______/_______/______ Sex: M / F Last 4 of Social Security #:__________________________

If Minor, name of guardian: ________________________ If married, name of spouse:___________________________

Primary phone number: __________________________ Secondary phone number: _____________________________

Employer/School: _______________________________ Occupation/Grade: __________________________________

Emergency contact: Name: ________________________ Relationship:___________ Phone number: ______________

Email Address (for appointment reminders, notifications):____

Communication Preference: Email Mail Phone

How did you hear about us? Google Facebook Advertisement Insurance Yelp

Patient Referral—Name:_________________________ Other:__________________________

VISION HISTORY

Have you or your family had any history of eye problems in the following areas?

	Self	Family		Self	Family
Glaucoma	☐	☐	Diabetic Eye Disease	☐	☐
Macular Degeneration	☐	☐	Keratoconus	☐	☐
Cataracts	☐	☐	Eye Surgeries	☐	☐
Eye Turns	☐	☐	Eye Allergies	☐	
Retinal Detachments	☐	☐	Eye Injuries/ Eye Pain	☐	
Amblyopia (Lazy Eye)	☐	☐	Eye Infections	☐	
			Dry Eye	☐	

Please describe any conditions marked above:____

Any concerns with eyes or vision: ____

Previous eye doctor: ________________________________ Date of last exam: _____/_____/_____

If you wear glasses, how old is your current pair? ___________________

If you currently wear contacts, please fill out the following:

Contact lens prescription (if known):____

Contact brand: _____________________________ How often do you replace your contacts? ______________________

Are your contacts comfortable?____________________ How old is your current pair of contacts?__________________

HEALTH HISTORY

Do you, or does your family have, any medical history of problems in the following areas?

	Self	Family		Self	Family
Digestive System	☐	☐	Nervous System (Headache, MS, seizures, etc.)	☐	☐
Skin	☐	☐	Respiratory (Asthma, emphysema, etc.)	☐	☐
Ear/Nose/Throat	☐	☐	Genitourinary (kidney, bladder, etc.)	☐	☐
Allergies/Immune System	☐	☐	Cardiovascular (cholesterol, hypertension, etc.)	☐	☐
Mental (depression, anxiety)	☐	☐	Endocrine (thyroid, diabetes, etc.)	☐	☐
Blood/Lymph	☐	☐	Musculoskeletal (arthritis, joint pain, etc.)	☐	☐

Please describe any conditions marked above: ____

____

Please list any medications you are currently taking: ____

____

Please list any medication allergies: ____

Primary care physician: ______________________________ Other medical doctors: _________________________________

Smoking Status: Never Smoked / Former Smoker / Current Every Day Smoker

Do you use illicit drugs?____________________ If yes, what type?____

Health Insurance Portability and Accountability Act—HIPAA

We respect the legal obligation to keep your health information private. We are obligated by law to give you notice of our privacy practice. The most common reason why we use or disclose your health information is for treatment, payment, or health care operations. If you would like a copy of our Notice of Privacy Practice please let the front desk know. By signing below it means that you are aware of our privacy practices and that you have been given an opportunity to obtain a copy of our policy.

Signed: ____ Date: __________________________

Payment Information

Payment is expected at the time services are rendered. The total cost of materials will be due at the time an order is placed. Please note there is a $25.00 fee for returned checks. I understand that I will receive a statement after 60 days if the insurance is not paid. I further understand that I am responsible for the total amount due of any amount unpaid by the insurance. Any denial or dispute of payment by my insurance company is my responsibility. If insurance is being billed by Rocky Mountain Family Vision, this signature serves as your "Signature on File."

Signed: ____ Date: __________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

Doctor's Signature Date