Lake Oconee Eye Care

Vision Source™

We treat you like family.

Welcome...

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we will be glad to help you.

PATIENT INFORMATION

Date ______________________________

Patient Name ______________________________
Last

____
First Middle Initial

Address ______________________________

City ______________________________

State ____________ Zip ____________

Email ______________________________

☐ Opt **IN** to our email Newsletter program. ☐ Opt **OUT**.

Whom may we thank for referring you?

____

SS/HIC/Patient ID# ______________________________

Sex ☐ M ☐ F Age ________ Birthdate ____________

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation ________________ Phone # ________________

Patient Employer/ School ______________________________

Employer/School Address ______________________________

Employer/School Phone (________) ________________

Spouse's Name ______________________________

Spouse's Birthdate ____________ Spouse's SS# ____________

PHONE NUMBERS

Home (________) ____________ Cell (________) ____________ Spouse's Work Phone (________) ____________

Best time and place to reach you ______________________________

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name ______________________________ Relationship ______________________________

Home (________) ____________ Cell (________) ____________ Work Phone (________) ____________

EYE HEALTH HISTORY

Practice Name ______________________________ Name of doctor ______________________________

Date of last visit ________________ Date of last eye exam ________________

Describe any problems you have with your contacts

____

____

Do you wear glasses? ☐ Yes ☐ No

☐ All the time ☐ Occasionally

☐ Reading ☐ Driving

Do you wear contacts? ☐ Yes ☐ No

Type ____________ Hours/Day ____________

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Condition	Yes	No
Bloodshot Eyes	☐ Yes	☐ No
Blurred Vision - Distance	☐ Yes	☐ No
Blurred Vision - Near	☐ Yes	☐ No
Burning Eyes	☐ Yes	☐ No
Cataracts	☐ Yes	☐ No
Color Vision, Poor	☐ Yes	☐ No
Crossed Eyes	☐ Yes	☐ No
Discharge from Eyes	☐ Yes	☐ No
Dizzy Spells	☐ Yes	☐ No
Double Vision	☐ Yes	☐ No
Dry Eyes	☐ Yes	☐ No
Eye Infection	☐ Yes	☐ No
Eye Injury	☐ Yes	☐ No
Eye Strain	☐ Yes	☐ No
Fainting Spells, Blackouts	☐ Yes	☐ No
Floaters or Spots	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No
Headaches	☐ Yes	☐ No
Itching Eyes	☐ Yes	☐ No
Light Sensitive	☐ Yes	☐ No
Loss of Vision	☐ Yes	☐ No
Migraine Headaches	☐ Yes	☐ No
Night Vision, Poor	☐ Yes	☐ No
Red Eyes	☐ Yes	☐ No
Seeing Halos	☐ Yes	☐ No
Seeing Flashes	☐ Yes	☐ No
Temporary Loss of Vision	☐ Yes	☐ No
Twitching Eyelid	☐ Yes	☐ No
Vision Poor	☐ Yes	☐ No
Watering Eyes	☐ Yes	☐ No

- OVER -

HEALTH HISTORY

Primary Care Doctor Name ______________________________ Date of last visit ________________

Address ____ Phone Number __________________

City ______________________________ State ____________________ Zip Code ____________________

Place a mark on "Yes" or "No" to indicate if you have had any of the following. Also place a mark to indicate if a blood relative has had any of the following problems:

Condition	Yourself		Family Members	
AIDS/HIV	☐ Yes	☐ No	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	☐ Yes	☐ No
Artificial Heart Valve	☐ Yes	☐ No	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	☐ Yes	☐ No
Bleeding	☐ Yes	☐ No	☐ Yes	☐ No
Blindness	☐ Yes	☐ No	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	☐ Yes	☐ No
Cataracts	☐ Yes	☐ No	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	☐ Yes	☐ No
Drug Sensitivity	☐ Yes	☐ No	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No	☐ Yes	☐ No
Eye Surgery	☐ Yes	☐ No	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No	☐ Yes	☐ No
Hay Fever	☐ Yes	☐ No	☐ Yes	☐ No
Heart Condition	☐ Yes	☐ No	☐ Yes	☐ No

Condition	Yourself		Family Members	
Hepatitis (Type _______)	☐ Yes	☐ No	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	☐ Yes	☐ No
Kidney Disease	☐ Yes	☐ No	☐ Yes	☐ No
Lazy Eye	☐ Yes	☐ No	☐ Yes	☐ No
Lupus	☐ Yes	☐ No	☐ Yes	☐ No
Migraine Headaches	☐ Yes	☐ No	☐ Yes	☐ No
Pacemaker	☐ Yes	☐ No	☐ Yes	☐ No
Poor Color Vision	☐ Yes	☐ No	☐ Yes	☐ No
Retinal Disease	☐ Yes	☐ No	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No	☐ Yes	☐ No
Shingles	☐ Yes	☐ No	☐ Yes	☐ No
Skin Conditions	☐ Yes	☐ No	☐ Yes	☐ No
Stroke	☐ Yes	☐ No	☐ Yes	☐ No
Thyroid Conditions	☐ Yes	☐ No	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No	☐ Yes	☐ No
Turned Eye	☐ Yes	☐ No	☐ Yes	☐ No

Are you pregnant? __________ Number of children __________

Tobacco use ______________ Alcohol Use ______________

MEDICATIONS

List any medications you are currently taking, including eye drops:

☐ List attached.

☐ Listed below:

____

____

Pharmacy Name ______________________________

Phone # (__________) ______________________________

ALLERGIES

List your allergies to medications or other substances:

____

____

____

____

____

HIPAA COMPLIANCE

I was given the option of reading the Lake Oconee Eye Care privacy policy. Name ____________________ Date ______________

MEDICARE/MEDIGAP - PATIENTS ONLY

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to

____ for any services furnished to me by that provider.

Name of Doctor or Clinic

____ ______________________

Signature of Beneficiary, Guardian or Personal Representative **Date**

____ ______________________

Please print name of Beneficiary, Guardian or Personal Representative **Date**