Brighter Future Vision Clinic PLLC

Patient Information

Name: Last _____ First _____ Middle Initial _____

Birth Date: ____/____/_____ Age: _____yrs. ____months Gender: M F

Address: _____City _____ State _____ Zip _____

Home Phone: _____ Cell: _____

Email: _____ @ _____ Referred By: _____

If minor: Parent(s) or Guardian name(s): _____

School: _____ Grade: _____

Siblings Name: _____ Gender: _____ __ Age: _____

_____ Gender: _____ __ Age: _____

Vision Insurance Information:

☐ **Check here if you don't have vision insurance**

Vision Insurance: □ VSP (last 4 of SS# _____) □ EyeMed □ Spectera/Optum □ Avesis

□ Medicaid □ CHP □ Medicare □ Other: _____

ID # (If applicable) _____ Name of Primary Policy Holder: _____

Patient Relationship to Insured: □ Self □ Spouse □ Dependent

Medical Insurance Information:

☐ **Check here if you don't have medical insurance**

Medical Insurance: _____ □ Medicaid □ CHP □ Medicare

ID # _____ Name of Primary Policy Holder: _____

Patient Relationship to Insured: □ Self □ Spouse □ Dependent Primary Holder D.O.B: _____

(Medicare Supplemental: _____ ID # _____)

Guarantor Information/Responsible Party:

(Person accepting financial responsibility)

Name of Guarantor: Last: _____ First: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Employer: _____Work Phone: _____ DOB:_____

Employer Address: _____ City: _____ State _____ Zip _____

***Social Security Number OR Driver's License # OR State ID #: _____**

General Medical History

Do you have a problem with any of the following bodily systems? If yes, please mark the box.

□ Allergic/Immunologic	□ Endocrine (glands)	□ Mental	□ Genitourinary
□ Ear/Nose/Throat	□ Bood/Lymph	□ Gastrointestinal	□ Nervous System
□ Musculoskeletal	□ Headaches	□ Cardiovascular	□ Respiratory

Do you smoke: □ Yes □ No If yes, how much: _____

Do you drink alcoholic beverages? □ Yes □ No

Please list current medications, including over-the-counter medicines, vitamins and supplements.

1. _____ 2. _____
3. _____ 4. _____

Do you use any other substances (including medical marijuana)? If yes, please list:

_____

Are you allergic to any medicines? □ Y □ N If yes, please list: _____

Do you or a family member have any of the following conditions? Please label (**S**= Self **F**=Family Member)

___ High Blood Pressure	___ Macular Degeneration	___ Glaucoma	___ Cataracts
___ High Cholesterol	___ Diabetic Retinopathy	___ Diabetes	___ Ocular Hypertension

Have you ever had an eye injury or surgery? □ Y □ N If yes, explain: _____

Are you interested in laser correction: □ Y □ N

Do any of the following conditions apply to you?

□ Dry Eyes	□ Distance Blur	□ Near Blur	□ Eye Swelling	□ Wears Glasses
□ Wears Contacts	□ Itchy Eyes	□ Red Eyes	□ Watery Eyes	□ Light sensitivity
□ Eye Strain	□ Eye Crossing	□ Eye Drifting	□ Dizziness	□ Eye Fatigue
□ Car Sickness	□ Sore Eyes	□ Tired Eyes	□ Mucous discharge	□ Frequent Headaches**

****If headaches, please mark all that apply:**

□ Stess induced □ Worse during work/school □ Worse during near centered tasks (reading)

□ Worse during or following visual demanding activity □ Worse with 3D movies

School/Recreational Symptoms *Please mark all that apply*

□ Tends to procrastinate	□ Easily distracted	□ Tends to lean into task
□ Poor attention to detail	□ Tends to work too close	□ Loses place while reading
□ Tends to reverse numbers, letters	□ Difficulty copying from board	□ Poor Memory
□ Skips/Omits/Repeats words	□ Difficulty completing tests	□ Difficulty managing time
□ Misaligns digits/columns of numbers	□ Does not enjoy work/school	□ Careless Errors
□ Tends to reread	□ Poor reading comprehension	□ Disorganized
□ Poor Spelling	□ Difficulty in Math	□ Poor balance
□ Tends to trip or bump into things	□ Poor judgment of distance	□ Tends to avoid sports
□ Poor eye-hand coordination	□ Clumsy, knocks thing over	□ Slow reaction time
□ Trouble hitting, catching, throwing	□ Performance not up to potential	□ Loses things
□ Says “I can’t” before trying	□ Low self esteem	□ Nervous
□ Gets frustrated easily	□ Cries easily/frequent tantrums	□ Lack of curiosity