

Performance Vision Care

Welcome to our office

Patient History Questionnaire

Mrs. Ms. Mr. Dr.		Date of Birth ___/___/___	Age
Address	City/State/Zip		
Phone Number	Work Number		
Occupation	E-mail address		
Date of last Physical	Family Doctor		
Date of Last Eye Exam	Location		
Type of exam you are here for (circle one):	Contact Lenses	Glasses	Both
How did you hear about us?			

Medical Information

Please indicate if you or any family members have:

	Self	Family	Please list current medications taken:		
Diabetes					
High Blood Pressure					
High Cholesterol					
Suffered from a stroke					
Thyroid Disease			Do you suffer from allergies?	Y	N
Glaucoma					
Macular Degeneration			If so, to what?		

Personal Eye Information

Do you currently wear glasses?	Y	N	Do you currently wear contact lenses?	Y	N
Do you use a computer frequently?	Y	N	Do you have a lazy eye?	Y	N
Do you get frequent headaches?	Y	N	History of eye injuries or surgeries?	Y	N
Do you ever see double?	Y	N	Do you ever see flashes of light?	Y	N
Do you have problems with glare at night?	Y	N	Do you ever see floaters?	Y	N

Insurance Information

Primary Insured's Name		I.D. Number	
Primary Insured's Date Of Birth		Relationship to Patient	
Name of Vision Insurance		Medical Insurance	

I request that payment of authorized benefits be made on behalf to Performance Vision Care for services rendered. In addition, I understand that I am responsible for any co-payments or deductibles required by my insurance company as well as any remaining balance not paid by my insurance.

Signature _____ Date _____

HIPAA Privacy Acknowledgement

I have been presented with the Notice of Privacy Policy of Performance Vision Care and have been offered a copy for my records.

Signature _____ Date _____