**PATIENT INFORMATION**

NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOME PHONE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CELL PHONE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-MAIL\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMERGENCY CONTACT\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PHONE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FAMILY MEMBERS WHO ARE PATIENTS AT YVC\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

REFERRED BY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PREFERRED METHOD OF NOTIFICATION ***TEXT\_\_\_\_ EMAIL\_\_\_\_ CELL PHONE\_\_\_\_ HOME PHONE\_\_\_\_***

**INSURANCE INFORMATION**

***Some services provided will not be covered by your vision insurance. These services may be covered by your medical insurance. We will do our best to submit both your vision and medical claims for you. If you have not met your deductible, your insurance company does not cover the procedure of if we do not accept your insurance, YOU will be responsible for the payment.***

**Please provide all insurance cards and information at the time of your appointment:**

PRIMARY CARE PHYSICIAN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PHONE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRIMARY INSURANCE CARD HOLDER’S INFORMATION**

NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_\_\_\_\_\_\_\_\_SOCIAL SECURITY#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS/PHONE if different from above\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*\*\*\*\*\*I UNDERSTAND THE ABOVE INSURANCE DISCLAIMER AND I AGREE TO THE CONDITIONS SET FORTH. I AGREE TO HAVE YARDLEY VISION CARE SUBMIT VISION AND/OR MEDICAL CLAIMS ON MY BEHALF.\*\*\*\*\*\***

SIGNATURE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HIPPA POLICY**

Have you received information on our HIPPA Policy (attached) **Yes** **No**

Do you have any questions regarding our HIPPA Policy? **Yes No**

SIGNATURE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any Drug Allergies\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Medications\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List all major surgeries\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any SERIOUS eye problems (surgery/lazy eye)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any Hobbies/Sports\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PERSONAL HEALTH Yes No Yes No Yes No**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Flashes/Floaters  Redness/Gritty Feeling  Blurred Vision  Loss of Side Vision  Dryness/Burning | 🞏 🞏  🞏 🞏  🞏 🞏  🞏 🞏  🞏 🞏 | Itching/Tearing  Loss of Vision  Distorted Vision/Halo  Styes/Chalazion  Mucous Discharge | 🞏 🞏  🞏 🞏  🞏 🞏  🞏 🞏  🞏 🞏 | Glare/Light Sensitivity  Tired Eyes  Double Vision  Eye Pain/Soreness  Foreign Body Sensation | 🞏 🞏  🞏 🞏  🞏 🞏  🞏 🞏  🞏 🞏  🞏 🞏 |

**LIFESTYLES Yes No ENT Yes No NEUROLOGIC Yes No**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Wears Glasses  Wears Contacts  Use Computer  Over 1 hr day  Drives over 1 hr day  Outdoors often | 🞏 🞏  🞏 🞏  🞏 🞏  🞏 🞏  🞏 🞏  🞏 🞏 | Asthma  Allergies/Hay Fever  Sinus Congestions  Dry throat/mouth  Chronic Cough | 🞏 🞏  🞏 🞏  🞏 🞏  🞏 🞏  🞏 🞏  🞏 🞏 | Headaches  Migraines  Seizures  **PSYCHIATRIC**  Depression/Dementia | 🞏 🞏  🞏 🞏  🞏 🞏  🞏 🞏 |

**RESPIRATORY CARDIOVASCULAR INTEGUMENTARY**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Asthma  Chronic Bronchitis  Emphysema  Uses CPAP/  Sleeping Apparatus | 🞏 🞏  🞏 🞏  🞏 🞏  🞏 🞏 | Heart Problems  High Blood Pressure  High Cholesterol | 🞏 🞏  🞏 🞏  🞏 🞏 | Eczema/Psoriasis  **LYMPH-BLOOD**  Anemia  Bleeding Problems  Immunologic/Cancer | 🞏 🞏  🞏 🞏  🞏 🞏  🞏 🞏 |

**MUSCULOSKELETAL GI/URINARY GENERAL**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Rheumatoid Arthritis  Osteo Arthritis  Gout  Muscle Pain  Joint Pain | 🞏 🞏  🞏 🞏  🞏 🞏  🞏 🞏  🞏 🞏 | Diarrhea/Constipation  Kidney/Bladder  **ENDOCRINE**  Thyroid/Other Glands  Diabetes | 🞏 🞏  🞏 🞏  🞏 🞏  🞏 🞏 | Pregnant/Nursing  Fatigue/Weakness  Fever  Weight loss/gain | 🞏 🞏  🞏 🞏  🞏 🞏  🞏 🞏 |
| **FAMILY HISTORY**  Blindness  Crossed Eyes  Glaucoma  Macular Degenerations  Retinal Detachment | 🞏 🞏  🞏 🞏  🞏 🞏  🞏 🞏  🞏 🞏 | ­­­­­­­­­­­­­­­­­­­­­­­­ **Relationship to You**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
|  |  |  | | | |

|  |
| --- |
| **SOCIAL HISTORY *This information is kept strictly confidential***  Yes, I would prefer to discuss my Social History information directly with my doctor (check box) 🞏  Do you use tobacco products? Yes 🞏 No 🞏 Do you drink alcohol? Yes 🞏 No 🞏  Have you ever been exposed to or infected with: Hepatitis 🞏 HIV 🞏 No 🞏  Do you drive? Yes 🞏 No 🞏 If yes, do you have difficulty when driving? Yes 🞏 No 🞏 If yes, please describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Any additional information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |