**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 FeelingBlurred VisionLoss of Side VisionDryness/Burning | 🞏 🞏🞏 🞏🞏 🞏🞏 🞏🞏 🞏 | Itching/TearingLoss of Vision Distorted Vision/HaloStyes/ChalazionMucous Discharge | 🞏 🞏🞏 🞏🞏 🞏🞏 🞏🞏 🞏 | Glare/Light SensitivityTired EyesDouble VisionEye Pain/SorenessForeign Body Sensation | 🞏 🞏🞏 🞏🞏 🞏🞏 🞏🞏 🞏🞏 🞏 |

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

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Wears Glasses Wears ContactsUse ComputerOver 1 hr dayDrives over 1 hr dayOutdoors often | 🞏 🞏🞏 🞏🞏 🞏🞏 🞏🞏 🞏🞏 🞏 | AsthmaAllergies/Hay FeverSinus CongestionsDry throat/mouthChronic Cough | 🞏 🞏🞏 🞏🞏 🞏🞏 🞏🞏 🞏🞏 🞏 | HeadachesMigrainesSeizures**PSYCHIATRIC**Depression/Dementia | 🞏 🞏🞏 🞏🞏 🞏🞏 🞏 |

 **RESPIRATORY CARDIOVASCULAR INTEGUMENTARY**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| AsthmaChronic BronchitisEmphysemaUses CPAP/Sleeping Apparatus | 🞏 🞏🞏 🞏🞏 🞏🞏 🞏 | Heart ProblemsHigh Blood PressureHigh Cholesterol | 🞏 🞏🞏 🞏🞏 🞏 | Eczema/Psoriasis**LYMPH-BLOOD**AnemiaBleeding ProblemsImmunologic/Cancer | 🞏 🞏🞏 🞏🞏 🞏🞏 🞏 |

 **MUSCULOSKELETAL GI/URINARY GENERAL**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Rheumatoid ArthritisOsteo ArthritisGoutMuscle PainJoint Pain | 🞏 🞏🞏 🞏🞏 🞏🞏 🞏🞏 🞏 | Diarrhea/ConstipationKidney/Bladder**ENDOCRINE**Thyroid/Other GlandsDiabetes | 🞏 🞏🞏 🞏🞏 🞏🞏 🞏 | Pregnant/NursingFatigue/WeaknessFever Weight loss/gain | 🞏 🞏🞏 🞏🞏 🞏🞏 🞏 |
| **FAMILY HISTORY**BlindnessCrossed EyesGlaucomaMacular DegenerationsRetinal Detachment | 🞏 🞏🞏 🞏🞏 🞏🞏 🞏🞏 🞏 | ­­­­­­­­­­­­­­­­­­­­­­­­ **Relationship to You**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |

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| --- |
| **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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |