

Patient Information

VisionOne 2118 Arlington Avenue Upper Arlington, OH 43221 487-1022

Patient Demographics

Last Name _____ First Name _____ M.I. _____

Address _____ City _____ Zip _____

Telephone _____ SS# _____
(“x” preferred phone#) (home) (work) (cell)

Marital Status: _____ Email address _____ Birth Date ____/____/____

Employer _____ Occupation _____
(patient’s or parent’s)

Emergency Contact/telephone # _____

Whom may we thank for referring you to us? _____

Other family members that are patients here _____

Vision Insurance _____ Medical Insurance _____

Name and Social Security # of Insured _____

Employer of the Insured _____ Insured’s Birthdate _____

Method of payment today Cash check MC/Visa/Discover

Diagnostic Information

Date of last eye exam (if not here) _____ Doctor’s name or location _____

Main reason for today’s visit _____

Do you currently wear glasses? Y/N Contact Lenses? Y/N – Type _____

Are you interested in: contact lenses Colored contacts or Refractive surgery?

Do you wear sunglasses with 100% UV protection? Y/N Do you need eye protection for sports? Y/N

Do you have a **personal** history of the following?

- | | | | |
|--|------------------------------------|---|---|
| <input type="checkbox"/> Problem Headaches | <input type="checkbox"/> Dry eye | <input type="checkbox"/> Cardiovascular disease | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Amblyopia (lazy eye) | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Respiratory disease | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Turned or crossed eye | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Autoimmune disease | <input type="checkbox"/> Eye injury |
| <input type="checkbox"/> Double vision | <input type="checkbox"/> Smoking | <input type="checkbox"/> Alcohol abuse | <input type="checkbox"/> Eye surgery or laser |

Other significant eye or general health issues _____

Allergies _____ Cancer(type) _____

Current medications: _____

Current general physician _____ Last seen _____

Do you have **family** history of Glaucoma Retinal detachment Macular degeneration Diabetes

I hereby authorize VisionOne to furnish information to insurance carriers or to other doctors involved in my care concerning my illness and treatments. I hereby assign to the physician all payments for medical/optical services rendered to me or my dependents. I understand that I am responsible for any amount not covered by my insurance. NOTE: CONTACT LENS PORTION OF EXAM MAY NOT BE COVERED BY INSURANCE.

SIGNATURE _____ DATE _____ **Thank You!**