# WELCOME TO OVIEDO VISION CENTER

PATIENT'S NAME______________________________________________ DATE____/____/____
First Middle Initial Last

ADDRESS__________________________________ EMAIL__________________________

CITY____________________ STATE________ ZIP____________ ☐ MALE ☐ FEMALE

PHONE(home)________________ PHONE(alternate)________________ SPOUSE____________

DATE OF BIRTH____/____/____ AGE________ SOCIAL SECURITY NO.________________

OCCUPATION__________________________ EMPLOYER__________________________

IN CASE OF EMERGENCY CONTACT__________________________ PHONE______________

PERSON RESPONSIBLE FOR PAYMENT____________________ RELATIONSHIP TO PATIENT____________

PATIENT HOBBIES/INTERESTS__________________________________________

FAMILY PHYSICIAN__________________________________ PHONE______________

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VISION INS. CO.________________________ MEDICAL INS. CO. ________________________

SECONDARY INSURANCE CO.____________________ POLICYHOLDER________________ DOB____/____/____

How did you hear of us? (Please circle) Insurance Family Yellow Pages

Doctor__________________ Other__________ Postcard Brochure Passing By Friend

If you were referred, whom may we thank for the referral?__________________________

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## GENERAL HEALTH (Check all that apply)

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Diabetes | ☐ | ☐ | Nerves | ☐ | ☐ |
| Hypertension | ☐ | ☐ | Glaucoma | ☐ | ☐ |
| Heart | ☐ | ☐ | Cataract | ☐ | ☐ |
| Thyroid | ☐ | ☐ | "Lazy Eye" | ☐ | ☐ |
| Asthma | ☐ | ☐ | HIV | ☐ | ☐ |
| Arthritis | ☐ | ☐ | Hepatitis | ☐ | ☐ |
| Kidney | ☐ | ☐ | Respiratory Disorder | ☐ | ☐ |
| Digestive Disorder | ☐ | ☐ | Allergies | ☐ | ☐ |
| | | | Other ______________ | | |

## CURRENT VISION PROBLEMS

- ☐ Headaches
- ☐ Spots
- ☐ Double Vision
- ☐ Light Sensitive
- ☐ Eyes tire Easily
- ☐ Blur at Night
- ☐ Redness
- ☐ Styes
- ☐ Dry Eyes
- ☐ Blur at Distance with Glasses
- ☐ Blur at distance w/out Glasses
- ☐ Blur at Near with Glasses
- ☐ Blur at Near w/out Glasses
- ☐ Eyes Water
- ☐ Eyes Burn
- ☐ Eyes Itch
- ☐ Eye Injury____________________
- ☐ Eye Surgery____________________
- ☐ Eye Diseases____________________

Any family members with above conditions? Please explain:__________________________

______________________________________________________________

Are you pregnant? ________ Other Conditions______________________________

Major Operations / Year______________________________________________

List any drugs or medications you are currently taking:__________________________

List any drug allergies:______________________________________________

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***ARE YOU INTERESTED IN CONTACT LENSES TODAY?*** _____*NO* _____*YES* Which type?________________

Which contacts are you currently wearing? (please circle) Hard Gas Permeable Bifocal Soft Disposable

Wearing time today__________hours. Average wearing time per day ________hours. Last time worn____________

I understand that I am responsible for my bill. I authorize the release of this information to all my insurance carriers, and for the doctor to act as my agent in helping me obtain payment from my insurance carriers. I authorize payment directly to my doctor, and permit a copy of this authorization to be used in place of the original. I understand that I am responsible for any co-payments, deductibles & non-covered services. I agree to pay all costs of collection, including reasonable attorney's fees in the event of non-payment.

______________________________________________
Signature (Patient or Guardian) Date