

ALLIED VISION PATIENT HISTORY FORM

Demographics

Dr. ___ Mr. ___ Mrs. ___ Ms. ___ Miss ___

Name _____ Gender M / F Date of Birth _____

Address _____

City _____ State _____ Zip Code _____ SSN (Last four digits) _____

Telephone (H) _____ (W) _____ (C) _____

E-Mail _____

Race (circle) American Indian or Alaskan Native / Asian / Black or African American / Hispanic /
Native Hawaiian or Other Pacific Islander / White

Ethnicity (circle) Hispanic or Latino / Not Hispanic or Latino Preferred Language (circle) English / Spanish

Communication Preference (circle) E-mail / Postal / Telephone

Insurance Information

Name of Insurance Company _____ ID# _____ Group # _____

Subscriber : _____ Patient relationship to subscriber : _____

Employment Status : Full-time _____ Part-time _____ Unemployed _____ Student _____

Name of Employer : _____

Marital Status : Married _____ Single _____

The preceding information is true to the best of my knowledge and I request any applicable payments of insurance be made on my behalf to Allied Vision Services for any services rendered. I authorize any holder of medical information about me to release to the insurance company and its agents any information needed to determine these benefits or benefits for related services. I understand that I am responsible for any referrals needed for services rendered here (if in a managed care insurance program), and for any fees not covered by my insurance company owed to Allied Vision Services.

Patient / Parent Signature _____ Date _____

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I have received a copy of Allied Vision Services of Plainsboro's Notice of Privacy Practices.

Patient/Parent Signature _____ Date _____

MEDICAL HISTORY

Name _____

Chief Complaint

How can we help you today? In this space please briefly tell us any signs and symptoms you are experiencing. (Vision plans cover "routine" eye exams. Most medical plans will only cover visit if there is a medical reason for the exam such as loss of vision, headaches, eye redness, eye pain, eye itching or burning, glaucoma, cataracts, floaters, dry eyes.)

Are you interested in purchasing new glasses today?	Yes _____	No _____
Do you currently wear contact lenses?	Yes _____	No _____
Are you interested in contact lenses?	Yes _____	No _____
Are you interested in Laser Vision Correction?	Yes _____	No _____
Are you interested in Cosmetic Eye Procedures (Botox, fillers, etc)	Yes _____	No _____

For patients that are inquiring about contact lenses or already wear contact lenses, there is an additional fee for contact lens fitting and evaluation. This is generally a one time fee that is necessary to take the additional measurements and evaluations to determine the appropriate type of contact lens for each individual patient. This may also include wearing instructions, a started solution kit, and any follow-up visits necessary to complete the fitting. Please initial that you have read and understand the above statement. _____

History of Present Illness (if any)

<i>Location</i>	Which eye has the problem ?	Right	Left	Both
<i>Quality</i>	Does the problem cause vision loss or blur?	Loss	Blur	
<i>Context</i>	Did the problem occur suddenly or gradually?	Sudden	Gradual	
<i>Severity</i>	How severe is the problem?	Mild	Moderate	Severe
<i>Modifying Factors</i>	Is it worse at any specific distance?	Distance	Near	Both
<i>Duration</i>	How long does the problem last?	Intermittent	Constant	
<i>Timing</i>	How long has the problem been occurring?	Short Term	Long Term	
<i>Associated Symptoms</i>	Are there any associated symptoms?	No	Headache	Nausea
<i>Interventions tried</i>	Does anything help alleviate the problem?	Yes _____	No	Nothing tried

Review of Systems

Do you or any family member now have or ever had any of the following?

	You	Family		You	Family
Allergies	_____	_____	Skin Conditions	_____	_____
Asthma	_____	_____	Neurological Problems	_____	_____
Lung Problems	_____	_____	Psychiatric Disorders	_____	_____
Heart Disease	_____	_____	Cancer	_____	_____
High Blood pressure	_____	_____	Headache	_____	_____
Diabetes	_____	_____	Eye/Head Injuries	_____	_____
Thyroid Disorder	_____	_____	Eye Surgery	_____	_____
Gastrointestinal Disease	_____	_____	Eye Disease	_____	_____
Urinary/Gen Disease	_____	_____	Glaucoma	_____	_____
Arthritis	_____	_____	Lazy Eye	_____	_____
Auto Immune Disorder	_____	_____			

Please list any medications you are currently taking. _____
Are you a smoker (pertains to ages 13 and older) ? Yes _____ No _____
Do you have any drug allergies? Yes _____ No _____ If yes, please list _____

Please initial and date _____