Patient Intake Form

Must be updated at each visit—please complete both sides

VOSS VISION

Patient Name: Head of Household/Bill payer:

Mailing Address: City: State/Zip Code:

Email: Home Tel #: Cell #:

Employer: Work Tel #: Occupation:

SS #: DOB: Age: **Height:** **Weight:**

Ethnicity: White African American Asian

American Indian/Inuit Hispanic Native Hawaiian or Other Pacific Island

Preferred Language:

Referred By:

Communication Preference: Phone Email Text

Reason for Today's Visit:

Do you wear glasses?	**Y**	**N**
If Yes, for: DISTANCE NEAR COMPUTER ALL 3		
Is your distance vision blurry?	**Y**	**N**
Is your near vision blurry?	**Y**	**N**
Is your computer vision blurry?	**Y**	**N**
Do you wear contact lenses?	**Y**	**N**

Do you have any of the following eye problems?

(Circle all that apply)

Cataracts	Itching
Macular Degeneration	Tearing
Glaucoma	Discharge
Diabetic Retinopathy	Blurred vision
Dry Eye	Eye pain
Eye infection or allergy	Sensitivity to lights
Floaters/Flashes of light	Headache
Iritis/Uveitis	Poor night vision
Retina defect/degeneration	Bothersome night glare
Redness	Double vision
Burning	Total loss of vision

Insurance and Payment Authorization

Today's professional fees will be paid for by:

Cash/Check **Credit Card**

Medicare **Vision Insurance**

Insurance Company:

ID #:

I request that payment of authorized insurance benefits be made on my behalf to Voss Vision. I authorize the release of information necessary to process claims. I permit my signature to be kept on file for future visits and insurance filings.

Due to the varying nature of vision and health insurance company plans, there may be additional fees or eligibility denials that my insurance dictates at the time of filing my insurance by Voss Vision. I understand and agree that regardless of my insurance benefits, I (or my guarantor) am responsible to pay for the balance on my account for all professional services and materials provided. I understand that if payment is not made in a timely manner, I may incur a 1.5% late fee on all balances of 60 days or more unless financial arrangements are made, and accounts over 90 days may be forwarded to a collection agency.

Signature Date

HIPAA (Privacy information) received

Signature Date

Name of Primary Care Physician:	Date of Last Medical Exam:

Family Health and Ocular History

Please check all that apply and state which relative

	N	Y	Relative
Cancer			
Type 1 Diabetes			
Type 2 Diabetes			
Hypertension			
Hyperthyroidism			
Hypothyroidism			

	N	Y	Relative
Cataract			
Macular Degeneration			
Glaucoma			

Eye Conditions: Have you had any of the following?	N	Y	?
Amblyopia ("lazy eye")			
Strabismus ("eye turn" or "cross-eyed")			
Eye surgery (explain):			
Corrective Surgery (Cataract, LASIK, PRK, RK) Circle one			

Patient Health History: Review of Symptoms

Do you currently, or have you ever had problems in the following areas?

	NO	YES	?
Constitutional			
Developmental Disabilities			
Cancer			
Fatigue Syndrome			
Ear, Nose, Throat			
Hearing Loss			
Sinusitis			
Dry Mouth			
Laryngitis			
Neurological			
Multiple Sclerosis			
Epilepsy			
Cerebral Palsy			
Tumor			
Stroke/CVA			
Migraine			
Autism Spectrum Disorder			
Psychiatric			
Depression			
Attention Deficit			
Anxiety Disorder			
Bipolar Disorder			
Cardiovascular			
Hypertension			
Stroke/CVA			
Heart Disease			
Vascular Disease			
Congestive Heart Failure			
Respiratory			
Cigarette Smoker			
Asthma			
Bronchitis			
Emphysema			
Chronic Obstruction			
Sleep Apnea			
Autoimmune/Allergy			
Rheumatoid Arthritis			
Lupus			
Sjogren's Syndrome			

	NO	YES	?
Gastrointestinal			
Crohn's			
Colitis			
Ulcer			
Acid Reflux			
Celiac Disease			
Genitourinary			
Kidney Disease			
Prostate disease/cancer			
STD – herpetic/chlamydia			
Pregnant (women only)			
Nursing (women only)			
Musculoskeletal			
Arthritis			
Osteoarthritis			
Fibromyalgia			
Muscular Dystrophy			
Ankylosing Spondylitis			
Osteoporosis			
Gout			
Integumentary (skin)			
Eczema			
Rosacea			
Psoriasis			
Herpes Simplex/Cold sores			
Herpes Zoster/Shingles			
Endocrine			
Type 2 Diabetes			
Type 1 Diabetes			
Thyroid dysfunction			
Hormonal dysfunction			
Hematological/Lymphatic			
Anemia			
Large-Volume blood loss			
Ulcer			
Hypercholesteremia			

Have you had any recent surgeries? N Y

If **YES**, please explain:

Please list all current medications AND dosages:

Please list any DRUG allergies:

Please list any OTHER allergies:

Social History

This information is kept strictly confidential

Ages 13 years or Older

Do you use Cigarettes/Tobacco? N Y

If **YES**, how many packs?

If **NO**, Quit Date?

Do you use Alcohol? N Y

Do you use any recreation drugs? N Y

Have you been exposed to or infected with any infectious or immune diseases? N Y

If **YES**, please explain: