PATIENT FORM

VIVID EYECARE

GENERAL INFORMATION

First, MI, Last (Legal Name)

Street Address

City, State, Zip

Phone, Cell

Phone, Home

Email

Preferred Contact Method ☐ *cell phone* ☐ *email* ☐ *text* ☐ *other* _____

Patient Social Security Number

Date of Birth

Gender Identity

Occupation/Employer/School ☐ *full-time* ☐ *part-time*

Marital Status ☐ *married* ☐ *single* ☐ *divorced* ☐ *separated* ☐ *widowed* ☐ *life partner*

Language, Race, Ethnicity

Emergency Contact Person and Phone

INSURANCE INFORMATION

Name of Vision Insurance

Vision Insurance Member Name

Vision Insurance Member ID#

Vision Insurance Member Date of Birth

Name of Primary Medical Insurance

Primary Member Name

Primary Insurance ID#

Primary Insurance Policy#/Group ID#

Primary Member Date of Birth

Primary Member Social Security Number

Primary Member Employer

Your Relationship to Primary Insurance Member ☐ *spouse* ☐ *child* ☐ *other* _____

Name of Secondary Insurance

Secondary Member Name

Secondary Insurance ID#

Secondary Insurance Policy #/Group ID#

Secondary Member Date of Birth

Secondary Member Social Security Number

Your Relationship to Secondary Insurance Member ☐ *spouse* ☐ *child* ☐ *other* _____

PATIENT FORM

VIVID EYECARE

EYE HISTORY

Date of Last Eye Exam

Currently Wear Glasses?

Currently Wear Contacts?

Reason for Today's Visit

Have you or a family member experienced, or been treated for, any of the following? Check all that apply.

Cataracts	☐ yes	☐ no	☐ family
Crossed Eye	☐ yes	☐ no	☐ family
Glaucoma	☐ yes	☐ no	☐ family
LASIK or RK	☐ yes	☐ no	☐ family
Lazy Eye	☐ yes	☐ no	☐ family
Macular Degeneration	☐ yes	☐ no	☐ family
Retinal Detachment	☐ yes	☐ no	☐ family

Are you currently experiencing, or have experienced, any of the following? Check all that apply.

- ☐ Blurry Vision ☐ near or ☐ distance
- ☐ Burning
- ☐ Discharge
- ☐ Double Vision
- ☐ Dryness
- ☐ Excess Tearing/Watering
- ☐ Eye Infection
- ☐ Eye Pain or Soreness
- ☐ Floaters or Spots
- ☐ Halos
- ☐ Headaches
- ☐ Itching
- ☐ Light Flashes
- ☐ Light Sensitivity
- ☐ Redness
- ☐ Sandy or Gritty Feeling

MEDICAL HISTORY

Have you or a family member experienced, or been treated for, any of the following? Check all that apply.

AIDS/HIV	☐ yes	☐ no	☐ family
Allergies	☐ yes	☐ no	☐ family
Arthritis	☐ yes	☐ no	☐ family
Asthma	☐ yes	☐ no	☐ family
Blood/Lymph	☐ yes	☐ no	☐ family
Cancer	☐ yes	☐ no	☐ family
Diabetes	☐ yes	☐ no	☐ family
Ears, Nose, Throat	☐ yes	☐ no	☐ family
Gastrointestinal	☐ yes	☐ no	☐ family
Heart Disease	☐ yes	☐ no	☐ family
High Blood Pressure	☐ yes	☐ no	☐ family
High Cholesterol	☐ yes	☐ no	☐ family
Kidney Disease	☐ yes	☐ no	☐ family
Lupus	☐ yes	☐ no	☐ family
Neurological	☐ yes	☐ no	☐ family
Psychiatric Disorder	☐ yes	☐ no	☐ family
Seizures	☐ yes	☐ no	☐ family
Skin Conditions	☐ yes	☐ no	☐ family
Stroke	☐ yes	☐ no	☐ family
Thyroid Dysfunction	☐ yes	☐ no	☐ family

Current Medications
(prescription and over-the-counter and dosage)

Medication/Food Allergies

Height **Weight**

Are you pregnant or nursing?

Do you smoke?

Have you ever smoked?