ADVANCED VISION CARE

Welcome To Our Office

Patient Name: _____ **Date of Birth:**_____/_____/_____

Phone Number:(_____**)**_____ **Email:**_____

Address:_____ **Apt #:**_____ **City:**_____ **State:**_____ **Zip:**_____

Occupation:_____

Whom May we Thank for Referring you? _____

Medications: _____

Allergies to Medications? _____

Do you smoke? **Yes or No** Do you drink? **Yes or No** Only socially?____ Other?_____

MEDICAL AND OCULAR HISTORY – Please CHECK the Appropriate Box

	Yes	No	Year Diagnosed	Family		Yes	No	Year Diagnosed	Family
High Blood Pressure					Eye Injury				
Diabetes (insulin, pills, diet control)					Eye Surgery including Laser				
Thyroid					Cataracts				
High Cholesterol					Cataract Implants				
Heart disease					Glaucoma				
HIV/AIDS					Macular Degeneration				
Hepatitis					Crossed Eyes				
Arthritis					Lazy Eye (Amblyopia)				
Cancer					Floaters or Flashing Lights				
Sinus					Blindness				
Allergies					Are you taking any eye drops?				
Headaches					Name of Drops:				
Other:					Other:				

I authorize the release of any medical information necessary to process this claim. I also request, authorize, and assign payment of all applicable benefits to the provider of these services, and agree to pay for any amounts not covered.

Patient Signature: _____ **Date:** _____/_____/_____

FOR DOCTOR'S USE ONLY

OC**Hx:** Last VF: Last Gonio: Target IOP: OC **Meds:**