VISION AT CEDAR CREEK

Patient History Form

PATIENT INFORMATION

Name_____ Birthdate_____ Cell Phone Number: _____

Address_____City/ Zip_____

Home Phone Number_____ E-mail _____ Occupation _____

INSURANCE

Health Insurance _____ Vision Plan_____

Primary Member Name_____ Relationship to Patient_____

Date of Birth_____ Last 4 of SS _____

HEALTH HISTORY

Date of last eye exam_____ Date of last physical exam_____

List any allergies_____

List any medications you are currently taking_____

_____

PERSONAL EYE CARE INFORMATION

Have you had: Eye Injury Y / N Eye Exercise / Vision Therapy Y / N Eye Surgery Y / N
LASIK Surgery Y / N If YES, when_____ If NO, would you be interested in a consultation? Y / N

Do you have any of the following?

Asthma	Y / N	Excessive Tearing	Y / N	High Blood Pressure	Y / N	Retinal Disease	Y / N
Burning Eyes	Y / N	Glaucoma	Y / N	High Cholesterol	Y / N	Sinus Problems	Y / N
Cataracts	Y / N	Family History of Glaucoma	Y / N	Itching Eyes	Y / N	Thyroid Problems	Y / N
Diabetes	Y / N	Floaters/Flashes of Light	Y / N	Lazy Eye	Y / N		
Dry Eyes	Y / N	Headaches	Y / N	Macular Degeneration	Y / N		

Do you have any other conditions such as MS, Arthritis, HIV/AIDS, Pregnancy, etc.?

_____

Do you wear contacts? Y / N Brand (if known)_____
If YES, number of years_____ If NO, are you interested in wearing contacts? Y / N

Main reason for today's visit_____

HIPPA PRIVACY

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

*Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

*Obtain payment for 3rd party payers.

*Conduct normal healthcare operations such as quality assessments and physician certifications.

I can be assured that Vision at Cedar Creek does not sell my personal health information of any kind to a third party for such party's own use. I authorize Vision at Cedar Creek to submit my vision benefit claims to my plan sponsor or health plan to receive reimbursement directly for the vision services and products that I have received from Vision at Cedar Creek.

I understand that Vision at Cedar Creek may use and disclose necessary personal health information (for example, my name, address, subscriber identification number, eye exam information and/or type of products provided) to another party to permit Vision at Cedar Creek to perform its administrative duties, provide me with eye care services and products, process my vision benefit claims and communicate with me regarding vision care services provided by Vision at Cedar Creek.

Vision at Cedar Creek may leave messages on my answering machine or with other family members _____(initial)

Vision at Cedar Creek has permission to text my cell phone _____ (Initial)

_____ _____

Patient/Guardian Signature Date