PURCELL VISION SOURCE

PATIENT INFORMATION

Date______________________ Patient Name____
First Name Middle Initial Last Name

Birthday ___________________ Social Security Number_______________________________________

☐Male ☐Female ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Race _____________________ Is English your primary language? ☐Yes ☐ Other ________________

Mailing Address__________________________________ City __________________ State ____ Zip_______

E-mail _____________________________________

Phone Numbers: Home ____________________________ Cell _________________________________

Employer ___________________________________ Occupation ___________________________________

In Case of Emergency Contact ______________________________ Phone Number ______________________

Who may we thank for referring you? ____

INSURANCE

Vision Insurance ______________________________ Medical Insurance _________________________________

Subscriber's Name ____________________________________ Relationship _____________________________

Subscriber's SSN_________________________________ Birthday___________ Employer _________________

Assignment of Benefits

I understand that my signature requests that payments from my insurance be made directly to the above named facility. I further authorize the release of any necessary information, including medical information, for the payment of this or any related claim.

____ ____ __________

Signature of patient, parent, or guardian Printed name of patient, parent, or guardian Date

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGMENT

The law requires that Purcell Eye Clinic PLLC make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

☐ I was given the opportunity to read, have read or had explained to me Purcell Eye Clinic PLLC's Notice of Privacy Practice prior to any services offered.

I authorize Purcell Eye Clinic PLLC to release my personal health information to the following individuals:

____

Our office may use texts and emails to communicate with you. Although HIPAA compliant, they may not be encrypted and complete privacy cannot be guaranteed.

☐ I authorize the use of text and email. ☐ I do not authorize the use of text and email to communicate with me.

____ ____ __________

Signature of patient, parent, or guardian Printed name of patient, parent, or guardian Date

EYE HEALTH HISTORY

Date of last eye exam ___________________________ Optometrist ____________________________________

Do you wear glasses? ☐No ☐Yes ☐All the time ☐Occasionally ☐Reading ☐Driving ☐TV

Are there any tasks you find difficult performing with your glasses? ☐No ☐Yes

Do you wear contact lenses? ☐ No ☐Yes

EYE HEALTH HISTORY CONTINUED

Do you experience or have you ever been diagnosed with any of the following?

☐ Blurred Vision - Distance ☐ Dry Eyes ☐ Lazy Eye ☐ Migraine Headache
☐ Blurred Vision - Near ☐ Eye Injury ☐ Loss of Vision ☐ Poor Color Vision
☐ Cataracts ☐ Glaucoma ☐ Macular Degeneration ☐ Poor Night Vision
☐ Crossed Eyes ☐ Headaches ☐ Other ________________________

Do you have family history of any of the following?

☐Glaucoma ☐Macular Degeneration ☐Cataracts ☐Color Blindness ☐Retinal Detachment ☐Blindness
Have you had any eye surgeries? ☐None ☐Cataract Surgery ☐LASIK ☐Other ___________________
Are you interested in any of the following? ☐LASIK ☐Contact Lenses

GENERAL HEALTH HISTORY

Name of Medical Doctor __________________________ Location of Medical Doctor _________________
Pharmacy Name ________________________________ Height _________ Weight __________

Have you or a family member been diagnosed with any of the following?

Condition	Yourself	Family Member	Condition	Yourself	Family Member
Cancer	☐	☐	Ear, Nose, Throat Condition	☐	☐
Heart Condition	☐	☐	Bleeding Disorder	☐	☐
High Blood Pressure	☐	☐	Lupus	☐	☐
Stroke	☐	☐	Skin Condition	☐	☐
Weight loss, fatigue, etc	☐	☐	Arthritis	☐	☐
Diabetes (Type ____)	☐	☐	Seizures	☐	☐
Thyroid Condition	☐	☐	Migraines	☐	☐
Gastrointestinal Condition	☐	☐	Psychiatric Condition (e.g. depression, anxiety)	☐	☐
Genitourinary Condition	☐	☐	Respiratory Condition (e.g. asthma, COPD)	☐	☐

Please list any other general health condition not listed above ________________________________

Pregnant? ☐Yes ☐No Tobacco Use? ☐Yes ☐No
Alcohol Use? ☐Yes ☐No Other substance use? ☐Yes ☐No

MEDICATIONS	ALLERGIES
List any medications you are currently taking, including eye drops ____________________ ____________________ ____________________ ____________________ ☐No medications ☐See medication list attached	List any allergies to medications or other substances ____________________ ____________________ ____________________ ____________________ ☐No Known Drug Allergies ☐Seasonal Allergies

Patient's Signature ____ Date __________________________