WELCOME TO DUNLAP VISION CENTER

** Please take a moment to fill out this form so that we may better serve you. We apologize for the inconvenience; however, current health care system documentation requirements leave us no alternative. Thank You!

Today's Date: ______________ Social Security #: ______________________________ Date of Birth: ______________
Last Name: ____________________ First Name: _______________________ Middle Init: ________ Marital Status: ______
Mailing Address: ____
Home Phone #: ____________________ Work Phone #: ____________________ Occupation: ______________________
Employer: ____________________ Employment Address: ____
Person responsible for this account: ______________________ Relationship to patient: ______________________
Address of responsible party: ____ Phone #: ______________________

COMPLETE MEDICAL HISTORY

Date of last medical check-up: ____________________ Name of medical doctor: ______________________________
List any medicines you currently take: ____
____
List any allergies to medicines you have: ____
List any surgeries you have had (including eyes): ____
Have you ever had a blood transfusion? ☐ No ☐ Yes If "yes," when: ____

Do you currently have any problems in any of the following areas?

	NO	YES	EXPLANATION FOR "YES" RESPONSES
EYES - Disease/Degeneration			
Blurred Vision			
Visual Disturbances			
Eye discomfort			
Eye turning in/out			
Other			
EAR/NOSE/THROAT (SINUS PROBLEMS, EAR INFECTIONS, ETC.)			
CARDIOVASCULAR (HEART, BLOOD VESSELS, ETC.)			
RESPIRATORY (ASTHMA, EMPHYSEMA, ETC.)			
GASTROINTESTINAL (ULCERS, COLITIS, ETC.)			
KIDNEY/GENITAL/BLADDER (INFECTIONS, LESIONS, STDs, ETC.)			
MUSCLES/BONES/JOINTS (ARTHRITIS, OSTEOPOROSIS, ETC.)			
SKIN (ACNE, WARTS, CANCERS, ETC.)			
NEUROLOGICAL (MULTIPLE SCLEROSIS, ETC.)			
PSYCHIATRIC (ANXIETY, DEPRESSION, ETC.)			
ENDOCRINE (DIABETES, HYPOTHYROIDISM, ETC.)			
BLOOD/LYMPH (ANEMIA, HIGH CHOLESTEROL, ETC.)			
ALLERGIC/IMMUNOLOGIC (HAY FEVER, LUPUS, AIDs, ETC.)			
GENERAL/CONSTITUTIONAL (FEVER, UNEXPLAINED WEIGHT LOSS, ETC.)			
OTHER			

* Please indicate a family history (F=Father M=Mother S=Sibling GP=Grandparent O=Other) for:

Glaucoma ________ Blindness ________ Diabetes ________ Hypertension ________ Cancer ________

Heart Disease ________ Other Eye Disease ____

(OVER)

SOCIAL HISTORY

Please check any of the following activities in which you participate frequently:

- ❑ Computer
- ❑ Golf
- ❑ Tennis
- ❑ Fishing/boating
- ❑ Reading
- ❑ Walking
- ❑ Running
- ❑ Hunting
- ❑ Needlework
- ❑ Cooking
- ❑ Gardening
- ❑ Aerobics
- ❑ Movies/TV
- ❑ Biking
- ❑ Camping/hiking
- ❑ Baseball
- ❑ Playing musical instruments
- ❑ Woodworking/carpentry
- ❑ Attending social functions
- ❑ Basketball/Football/Soccer
- ❑ Other ______

Do you smoke? ❑ No ❑ Yes If "yes,": ❑ occasional ❑ half-pack/day ❑ one pack/day ❑ over one pack/day

Do you drink alcohol? ❑ No ❑ Yes If "yes,": ❑ occasional ❑ 1 per day ❑ 2-3 per day ❑ 4+ per day

OCULAR HISTORY

If this is your first exam with us, when was your last eye exam? ______ Location ______

Do you currently wear glasses? ❑ No ❑ Yes If so, how old is your current pair? ______

Are you restricted to corrective lenses on your Driver's License? ❑ No ❑ Yes

Do you currently wear contact lenses? ❑ No ❑ Yes If so, what type? ______

Have you ever tried contact lenses in the past and discontinued wearing them? ❑ No ❑ Yes If "yes," why?

______

Has either of your eyes ever been injured? ❑ No ❑ Yes If "yes," explain: ______

______

EYECARE INTERESTS

- ❑ Computer glasses
- ❑ Photochromatic lenses that turn dark outside and lighten indoors
- ❑ No-line bifocals
- ❑ Aspheric lenses that reduce eyes magnification
- ❑ Thinner and lighter lenses
- ❑ "invisible" lenses with anti-reflective coating
- ❑ Sunglasses with UV protection
- ❑ Polarized sunglasses
- ❑ Sports goggles
- ❑ Impact resistant lenses for hobbies/ sports
- ❑ Vitamins to protect eye health/good vision
- ❑ Safety glasses for work
- ❑ Golf glasses
- ❑ Child-safe glasses
- ❑ Scratch resistant lenses
- ❑ Regular contact lenses
- ❑ Colored contact lenses
- ❑ Contact lenses that can be disposed of daily
- ❑ Contact lenses for special occasions or part-time wear
- ❑ Bifocal contact lenses
- ❑ Contact lenses for astigmatism
- ❑ Laser Vision correction

INSURANCE INFORMATION

* Please present insurance card(s) to our Receptionist **before** your examination begins so they it/they may be photo copied and included with your records. This is to insure that any covered services we might provide will be properly filed for your reimbursement.

PATIENT ASSIGNMENT AND RELEASE AND PRIVACY PRACTICES

I, the undersigned, do hereby give Dunlap Vision Center my permission to: 1) file my insurance claim, releasing all pertinent information to my insurance carrier(s) or the Social Security Administration, and 2) contact any medical profession deemed necessary for the furtherance of my medical care. I understand that: 1) my consent here is good for all services for the remainder of my life, and 2) I am responsible for any balance left unpaid by my insurance carrier(s). I certify that: 1) the information I have provided here is correct, and 2) I have complete authority to execute this document on behalf of myself or as the responsible party for the patient.

I acknowledge that I have been given the opportunity to read Dunlap Vision Center's Notice of Privacy Practices.

Signature: ______ Date: ______

Physician's Signature/History Reviewed: ______

SUBSEQUENT EXAMINATION - HISTORY REVIEW and PRIVACY PRACTICE REVIEW

I, the undersigned, have reviewed this document and made all necessary changes to insure that my history information is current and complete:

Signature: ______ Date: ______ Physician's Signature/subsequent Hx review: ______

Signature: ______ Date: ______ Physician's Signature/subsequent Hx review: ______

Signature: ______ Date: ______ Physician's Signature/subsequent Hx review: ______

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