

Hema/Lymph:

Musculoskel:

Neuro:

Psych: Resp:

Bleeding problems____

Swollen joints____

Psychiatric Problems_

Breathing Problems

Dizziness

Established Patient History Form Thank You!

A MEMI	OPTOMETRY, P.A. BER OF VISION SOURCE		Chart#
Patient Name		Date of Birth	
Address			
Home Phone	Cell Phone	e D	aytime Phone
Email —			Family Dr
	y medication allergies?		
List all medicati	ons you are currently taking:		
What other surg	eries have you had since your last vis	it with our office?	
_	ave affected you recently:		
Discomfort with your eyes		Headaches	Dry Eyes
Problems with glare or reflections		Floaters or flashes of ligh	
	blurry with current glasses	Reading blurry with curre	
	ed in information about Contact Lens		
Are you interested in information about Laser Eye			
		YES or	
Do you anticipate getting new glasses today?			
•	Contact Lenses today?	YES or	_NO
List any family	members and their relationship to yo		
	Glaucoma	Macular Degeneration	Blindness
	Cataracts	Crossed or lazy eye	Other eye disease
Please mark any	of the following conditions which ye	ou have had in the past several w	reeks?
Allergy/IMM:	Allergies		
Cardio:	High Blood Pressure	Stroke	Chest Pains
Constitutional:		Feel "sick"	
Endocrine:	Diabetes	Thyroid disesase	-
Gastro:	GI problems or ulcers		
Head:	: Kidney/Bladder problems Headaches	Ear/Nose/Throat Problem	ems
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I authorize the release of any medical other Protected Health Information necessary to process this claim, or provide treatment. I also request payment of government and insurance benefits payable to Lifetime Eyecare Optometry, P.A. I am responsible for the deductible, co-insurance, and all non-covered services. I am responsible for any and all non-covered services related to insufficient or incorrect insurance information provided to Lifetime Eyecare. I acknowledge that I have been afforded the opportunity to review Lifetime Eyecare's Notice of Privacy Practices and have been given a copy if requested.

Signature:	Date:
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