Patient Information

Name________________________________ Occupation_________________________________ DOB_____/_____/______
Medical Doctor____________________________ Last Physical Exam _____/_____/_____ Last Eye Exam _____/_____/______
Hobbies____
Medications____
Allergies____

Ocular History	Family	Self
Cataracts		
Glaucoma		
Macular Degeneration		
Eye Allergies		
Styes or Chalazion		
Crossed Eyes or Amblyopia		
Other, please explain		

Major medical/surgical history:_____________________________
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Allergic	Family	Self
Seasonal Allergies	☐	☐
Other	☐	☐
Cardiovascular		
Blood Pressure	☐	☐
Cholesterol	☐	☐
Heart Disease	☐	☐
Stroke	☐	☐
Constitutional		
Fatigue		☐
Nausea, Fever		☐
Weight gain		☐
Weight loss		☐
Endocrine		
Hypoglycemia	☐	☐
Gout	☐	☐
Thyroid Disorder	☐	☐
Diabetes I (insulin)	☐	☐
Diabetes II (non-insulin)	☐	☐
Gastrointestinal		
Constipation		☐
Diverticulitis	☐	☐
Gall Bladder Disease	☐	☐
Gastric Reflux (GERD)	☐	☐
Hepatitis	☐	☐
Pancreatitis	☐	☐
Stomach Cancer	☐	☐
Ulcers	☐	☐

Genitourinary	Family	Self
Pregnant		☐
Menopause		☐
Bladder Infections	☐	☐
Dialysis	☐	☐
Renal Cancer	☐	☐
Ears, Nose, Throat		
Sinusitis	☐	☐
Deafness	☐	☐
Vertigo	☐	☐
Hematologic, Lymphatic		
Sickle Cell Disease	☐	☐
Leukemia	☐	☐
Lyme Disease	☐	☐
Lymphoma	☐	☐
Immunologic		
AIDS/HIV	☐	☐
STD	☐	☐
Lupus	☐	☐
Cancer	☐	☐
Integument		
Eczema	☐	☐
Skin Cancer/Rash	☐	☐
Musculoskeletal		
Arthritis	☐	☐
Rheumatoid Arthritis	☐	☐
Cerebral Palsy	☐	☐
Multiple Sclerosis	☐	☐
Muscular Dystrophy	☐	☐

Neurological	Family	Self
Nerve Palsy	☐	☐
Epilepsy	☐	☐
Seizures	☐	☐
Headaches	☐	☐
Migraines	☐	☐
Psychiatric		
ADD/ADHD	☐	☐
Anxiety	☐	☐
Depression	☐	☐
Sensory Processing	☐	☐
Respiratory		
Asthma	☐	☐
COPD	☐	☐
Social		
Tobacco	☐	☐
E-Cigarette	☐	☐
Alcohol	☐	☐

VFE: WNL
PD: ________
____ ____
Stereo: WNL
Color: WNL

Polycarb
1.67
1.74
Aspheric

A/R
Transitions
Polarized

Follow-up: ________

SV
Bifocal
Trifocal
PAL
S Series

Order:
Trials or Supply

Signature___________________________________ Date_____/_____/_____

N E - G C - RP

Patient Information

Responsible Party (skip if same as patient information)
Name___________________________________
Address_________________________________
City ______________ State ______ Zip_______
Home#__________________ DOB___________
Work#__________________ Male or Female
Cell#___________________
SSN#___________________________________

Patient Information
Name_____________________________________
Address___________________________________
City ______________ State ______ Zip_______
Home#__________________ DOB____________
Work#__________________ Male or Female
Cell#___________________ Married or Single
SSN#_____________________________________
Employer__________________________________
Occupation_______________________________
Email____________________________________
Race (check one):
Cauc.____ A. Am.____ N. Am.____ Other:_____
Ethnicity: Hispanic____ Non-Hispanic____
Primary Language: English___ Spanish____
Other____

At Within Sight P.L.L.C. we utilize an automated system to confirm and request appointments, receive appointment reminders, and be notified when eyewear is available for pick up. This system can also be used to submit surveys, reviews, and refer friends.

May we send you text reminders? Yes No
May we send you email reminders? Yes No
May we use your name/picture for marketing? Yes No

Medical Insurance
MEDICAL INSURANCE________________________
Who holds the insurance____________________
Relationship to patient___________ DOB_______
Policy#___________________________________
Group#___________________________________
SSN#_____________________________________

Vision Insurance
VISION INSURANCE________________________
Who holds the insurance____________________
Relationship to patient___________ DOB_______
Policy#___________________________________
Group#___________________________________
SSN#_____________________________________

What brings you to the office today? *Annual Vision Exam* *Contact lens Exam* *Medical Exam*

________ I acknowledge that I have received a copy of Within Sight P.L.L.C. Notice of Privacy Policies. I also acknowledge this information is always available on their website ***withinsightvision.com***.

________Digital retinal photography provides both the patient and the doctor with a digital photo of the back of the patient's eye and reduces the need for dilation if the pupils are large enough for clear, readable photos. This process can aid in the early detection of several disorders and eye diseases, such as brain tumors, glaucoma, diabetes, macular degeneration, and retinal lesions. **Insurance does not cover this**
There is an additional $39.00 charge for the Digital Retinal Photography Testing

Would you like a retinal photo taken today? Yes No

Person(s) authorized to receive information or materials from this office which pertain to me, my health status, my account at this office, or pending health or financial responsibilities related to this office. (**We are required to have you complete this by HIPAA/Privacy laws.**)

Name	Email	Phone	Relationship

Signature____ Date______________________________