Date: ______________________

Welcome Form

Thank you for choosing ***CVC Vision Centers – Dr. Jeffrey Rautio*** to take care of your vision and eye care needs

Patient Name: ______________________ Date of Birth: ____________ Age: ______

Race: ______________ Ethnicity: ______________ Preferred Language: ______________

Communication Preference (circle): Email Telephone Mail Sex (circle): Male Female

Home Address: ______________________ City: ______________ State: ______ Zip: ________

Home Phone: ______________ Cell Phone: ______________ Email address: ______________

Occupation: ______________ Employer: ______________ Work Phone: ______________

Status (Circle): Married Partner Single Divorced Widowed Minor Other: ____________

Spouse/Significant Other Name: ______________________Number of Children/Ages: ____________

Have we seen other members of your family? ☐ Yes ☐ No If yes, whom: ______________________

Whom may we thank for referring you to us (Circle)? Ad Insurance Plan Other Friend: ____________

Date of last eye exam? __________ Name of Eye Doctor: ______________ Phone Number: ____________

Date of last medical exam: __________ Name of Medical Doctor: __________ Phone Number: ____________

Who should we contact in case of emergency? ______________________ Phone Number: ____________

If patient is a minor, responsible party: ______________________ Relationship: ____________

Insurance information and Financial Arrangements

VISION Insurance Carrier: ______________________ ID Number: ______________________

Policy Holders Name: ______________________ SS#: ______________ Date of Birth: ____________

MEDICAL Insurance Carrier: ______________________ ID Number: ______________________

Policy Holders Name: ______________________ SS #: ______________ Date of Birth: ____________

I hereby authorize CVC Vision Center to furnish information to insurance carriers concerning my illness and treatment, and I hereby assign to my optometric/medical provider all payments for optometric/medical services rendered to myself or dependents. I understand that I am responsible for any amounts not covered or paid by insurance.

Signature: ______________________________________ Date: ______________________

HIPAA Information

I have reviewed or received a copy of CVC Vision Centers Health Insurance Portability and Accountability Act (HIPAA). By signing below, I authorize the disclosure of my health information as described in the form.

Signature: ______________________________________ Date: ______________________

-OVER-

Health History Form

Your answers on this form will help your eye care provider at ***CVC Vision Centers*** to better understand your vision/medical concerns and conditions. Thank you!

Main reason for today's visit: ____

Do you wear glasses?	☐ Yes ☐ No	If yes (circle):	Distance	Reading	Both		
Do you wear contact lenses?	☐ Yes ☐ No	If yes (circle):	Soft/Disposable:	Daily	2 Week	Monthly	RGP
If not, are you interested in contacts?	☐ Yes ☐ No	If yes (circle):	Full-time	Part-time	Monovision		
Are you interested in laser eye surgery?	☐ Yes ☐ No	If yes, time table (circle)?	Immediately	Inquiring			
Do you work on a computer?	☐ Yes ☐ No	If yes, how many hours per day: ____________					

Eye/Ocular History

___Blurred vision (circle): Distance Near
___Eye infections
___Floaters (spots)
___Burning eyes
___Double vision
___Eye injury (Type: ________________)
___Flashes of light
___Watery eyes
___Dry eyes
___Eye strain
___Light sensitivity/Glare
___Red or Itchy eyes

Ocular Surgical History (List operations and dates):____

REVIEW OF SYSTEMS/SYMPTOMS: *Please check any current symptoms that apply to you.*

Constitutional
___Recent fevers/sweats
___Unexplained weight loss/gain
___Unexplained fatigue/weakness

Cardiovascular
___Angina/Chest pains
___Heart Attack
___Palpitations/Short of breath

ENT
___Hearing loss
___Sinus problems
___Seasonal allergies

Gastrointestinal
___Heartburn/Reflux
___Nausea/Vomiting/Diarrhea
___Pain in abdomen

Genitourinary
___Painful/Bloody urination
___Leaky urine
___Discharge

Musculoskeletal
___Muscle/Joint pain
___ Recent back pain

Neurological
___Headaches/Fainting
___Memory loss

Psychiatric
___Anxiety/stress
___Sleep problem

Respiratory
___Cough/Wheeze
___Coughing up blood

Skin
___Rash
___New or change in mole

Endocrinology
___Cold/Heat intolerance
___Increase thirst/Appetite

Blood/Lymphatic
___Easy bruising/Bleeding
___Unexplained lumps

PERSONAL/FAMILY MEDICAL HISTORY: *Please check all that apply.* *Key: M/Mother, F/Father, S/Sibling, A/Aunt, U/Uncle, GM-GF/Grandparents

	Self	Family*		Self	Family*		Self	Family*
Alcoholism	___	___	Asthma	___	___	High Blood Pressure	___	___
Diabetes	___	___	Glaucoma	___	___	Heart Disease	___	___
Cancer	___	___	Cataracts	___	___	High Cholesterol	___	___
Stroke	___	___	Blindness	___	___	Macular Degeneration	___	___
Headaches	___	___	Depression	___	___	Retinal Detachment	___	___
Lazy eye	___	___	Anxiety	___	___	Thyroid condition	___	___
Seizures	___	___	Migraines	___	___	Kidney Disease	___	___
HIV/Aids	___	___	Emphysema	___	___	Retinitis Pigmentosa	___	___

Social History

Tobacco use (circle): Cigarettes Packs/day: ______ Cigar Cigars/day: _____ Chewing tobacco Pipe

Do you drink alcohol? ☐ Yes ☐ No If yes, how many drinks/week? ________ Is it a concern for you or others? ☐ Yes ☐ No

Surgical History: Please list all prior operations: ____

Medications: (Prescription and non-prescription medicines, vitamins, home remedies, birth control pills, etc): ____

Medication Allergies or reactions: ____

Doctor Reviewed (Initials): __________