Clear View Optometry Patient Profile

Last Name Mr/Mrs/Misss/Ms/Dr	First Name	Age	Birth Date

Address	Apt.#	City	State	Zip

Home Phone	Work Phone	Cell Phone ☐Texting OK
Email	Emergency Contact Name	Emergency Contact Phone Number

Occupation	Employment Status	Marital Status	Referred By

Vision Insurance Carrier	Name Of Primary Insured	SSN Or ID Of Primary Insured
Name Of Employer	Primary Birth Date	Pt's Relationship To Primary

Date Of Last Eye Exam Dilated? Yes/No	Type Of Exam Needed? ☐ Glasses ☐ Glasses And Contacts ☐ Contacts	1. Do You Presently Wear Eyeglasses? Yes / No 2. Do You Presently Wear Contact Lenses? Yes / No 3. Have You Ever Worn Contact Lenses? Yes / No 4. If No, Are You Interested In Trying Contact Lenses? Yes / No

Do you have any eye conditions or problems? Yes/No What kind?_____

Have you had any eye surgery? Yes/No Type_____ Date_____

Have you had an eye injury? Yes/No Kind _____ Date _____

Do you have Glaucoma? Yes/No Cataracts? Yes/No Dry eyes? Yes/No Macular Degeneration Yes/No

Retinal detachment? Yes/No Blurred vision? Yes/No Additional Information_____

What is your general health?_____

Do you have problems with any of these systems? (**Please circle yes or no**.)

Gastrointestinal	Yes/No	Nervous	Yes/No	Endocrine (glands)	Yes/No	Eyes	Yes/No
Ears/Nose/Throat	Yes/No	Urinary	Yes/No	**High Blood Pressure**	Yes/No	Blood/lymph	Yes/No
Cardiovascular	Yes/No	Muscles/bones	Yes/No	Allergic/immunologic	Yes/No	Mental	Yes/No
Respiratory	Yes/No	Headaches	Yes/No	Integument (skin)	Yes/No	Pregnant	Yes/No

Please explain_____

Diabetes Yes/No Type_____ Date of diagnosis_____

Have you had any operations? Yes/No Kind?_____ When?_____

Name of family doctor _____ Date of last visit_____ Date of last tetanus shot_____

Family History

High blood pressure	Yes/No Relation _____	Diabetes	Yes/No Relation _____
Macular degeneration	Yes/No Relation _____	Cataracts	Yes/No Relation _____
Retinal detachment	Yes/No Relation _____	Glaucoma	Yes/No Relation _____

Please list any medications (prescription or non-prescription) you are currently taking: Check if none ☐	Are you allergic to any medication(s) that you are aware of? ☐No ☐Yes If yes, please list:

____I authorize CLEAR VIEW OPTOMETRY to release any medical information necessary to my insurance company to process this claim. This authorization shall apply to all claims submitted on my behalf or for my dependents. I also authorize payment of medical benefits to CLEAR VIEW OPTOMETRY. I understand that quoted benefits are not a guarantee of payment from the insurance company and that I am financially responsible for all charges not covered by my insurance as well as any deductible and/or co-pay.

____I acknowledge that I have been given a copy of Clear View Optometry's "Notice of Privacy Practices."

____I acknowledge that I have been given a copy of Clear View Optometry's "Office Policy" which states "Due to the custom nature of glasses, all Prescription Frame and Sunglass Sales are Final: No refunds or exchanges will be given. Payment is expected at time professional services are rendered and no refunds will be made for services."

Signed_____ Date_____

(Must be at least 18-years-old. If not patient, write relationship to patient next to signature).