# 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<br><br>Dilated? Yes/No | Type Of Exam Needed?<br>□ Glasses<br>□ Glasses And Contacts<br>□ Contacts | 1. Do You Presently Wear Eyeglasses? Yes / No<br>2. Do You Presently Wear Contact Lenses? Yes / No<br>3. Have You Ever Worn Contact Lenses? Yes / No<br>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?<br>□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" and a copy of their "Office Policy."

Signed_____ Date_____

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