General

Are you currently being treated for.....

Date						
ADD/ADHD						
Anxiety/Depression						
Asthma/COPD or Emphysema						
Diabetes						
High blood pressure/high cholesterol						
Multiple Sclerosis						
Rheumatoid arthritis or Ankylosing Spondylitis						
Sarcoidosis						
Thyroid abnormalities						
Do you smoke?						
Do you drink alcohol?						
Are you pregnant/nursing?						

Eyes

Allergies						
Cataracts						
Conjunctivitis (pink eye)						
Corneal Dystrophy						
Dry Eyes						
Diabetic Retinopathy						
Glaucoma						
Lasik/PRK/RK						
Macular Degeneration						
Macular pucker/hole/edema						
Optic Neuropathy						
Retinal Detachment						
Strabismis (eye turn/patching)						
Stys (meibomian gland)						
Uveitis (Iritis)						
Past eye surgery or trauma						

Meds

Do you currently take any medications (prescription or over the counter) for.....

ADD/ADHD						
Allergy						
Aspirin/Coumadin/Vitamin E						
Anxiety/Depression						
Birth Control Pills/Hormone Replacement						
Diabetic Oral or Insulin						
High blood pressure/cholesterol						
Plaquinil/hydroxycholoroquine						
Steroids (Prednisone)						

Please list medications_____

_____

Please list medication allergies_____

Please list any eye diseases in your family_____

Please list any other general health or eye condition not listed above_____

Veld Vision Center

New Patient

Name_____ Birth Date _____

Address_____ Phone _____

City_____Zip_____ Email_____

SS#_____Occupation_____last eye exam_____

Insurance Carrier_____

Member name of policy holder_____Member Date of Birth_____

Person responsible for this bill_____

How did you hear about us?_____

Were you referred by anyone?_____

HIPAA Notice of Privacy Practices

I hereby acknowledge that a copy of the Notices of Privacy Practices of Veld Vision Center has been made available to me.

Sign here_____Date_____

Changes

Change of Address _____

Date of Address change_____

Change of phone number_____ Date of phone number change_____

Change of email_____ Date of email change_____

Change in Insurance Carrier_____Date_____

Member name of policy holder_____Member Date of Birth_____

Person responsible for this bill_____