Boulder Vision Associates Patient History Form - page1

Last Name | First Name | Middle Initial

Birth Date | Age

Address | City | State | Zip

Employer/Occupation/School | Email

Daytime/Cell Phone | Home Phone | Gender ☐ Male ☐ Female

Emergency Contact | Relationship | Contact Phone

Parent or Guardian (if under 18)

Reason for your visit today? ☐ Exam ☐ Contacts ☐ LASIK ☐ Consultation ☐ Office visit ☐ Emergency

New Patients: how were you reffered? ☐ physician ☐ phone book ☐ family/friend name ☐ advertisemet ☐ other

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CURRENT VISUAL SYMPTOMS

Are you experiencing any of the following:

- ☐ Difficulty seeing at distance?
- ☐ Difficulty seeing up close?
- ☐ Fatigue reading?
- ☐ Vision problems with a computer?
- ☐ Seeing flashes of light?
- ☐ Floaters or spots in your vision?
- ☐ Double vision?
- ☐ Temporary vision loss?
- ☐ Amblyopia (lazy eye)?
- ☐ Strabismus (eye turn)?
- ☐ Poor night vision?
- ☐ Light sensitivity?
- ☐ Foreign body sensation?
- ☐ Burning sensation?
- ☐ Dry or watering eyes?
- ☐ Redness?
- ☐ A recent eye injury?
- ☐ Contact lens blur?
- ☐ Contact lens dryness?
- ☐ Allergies?
- ☐ Headaches?

PERSONAL EYE HEALTH INFORMATION

Do you have or have you ever had:

- ☐ Contact Lenses?
- ☐ Eyeglasses?
- ☐ Dilated?
- ☐ Contact Lens Fitting?
- ☐ Eye Surgery?
- ☐ Vision Training?
- ☐ Major Surgery or Illness?

Hours per day spent at computer?

Date of last exam?

FAMILY HISTORY

- ☐ Cataracts? Relation
- ☐ Diabetes? Relation
- ☐ Eye Disease? Relation
- ☐ Glaucoma? Relation
- ☐ High Blood Pressure? Relation
- ☐ Macular Degeneration? Relation
- ☐ Retinal Detachment? Relation
- ☐ Eye Disease? Relation

Please explain:

Please list any medications you are taking:

Please list any medications you are allergic to:

Primary Care Physicians Name:

If you have any special vision concerns please explain:

Boulder Vision Associates Patient History Form - page 2

PERSONAL EYE HEALTH INFORMATION (cont.)

Do you have any of the following conditions:

- ☐ Allergies? Explain:
- ☐ Anxiety/Depression? Explain:
- ☐ Arthritis? Explain:
- ☐ Asthma? Explain:
- ☐ Autoimmune Disorder? Explain:
- ☐ Blood/Lymph Disorder? Explain:
- ☐ Cancer? Explain:
- ☐ Cataracts? Explain:
- ☐ Chemical Addiction? Explain:
- ☐ Chronic Pain? Explain:
- ☐ Colorblindness? Explain:
- ☐ Diabetes? Explain:
- ☐ Ear/Nose/Throat Issue? Explain:
- ☐ Endocrine Disorder? Explain:
- ☐ Eye Disease or Surgery? Explain:
- ☐ Gastrointestinal Disorder? Explain:
- ☐ Genitourinary Disorder? Explain:
- ☐ Genetic Disorder? Explain:
- ☐ Glaucoma? Explain:
- ☐ Heart Problems? Explain:
- ☐ High Blood Pressure? Explain:
- ☐ High Cholesterol? Explain:
- ☐ Hepatitis? Explain:
- ☐ Hormone Replacement Therapy? Explain:
- ☐ Keratoconus? Explain:
- ☐ Lung Disease? Explain:
- ☐ Macular Degeneration? Explain:
- ☐ Multiple Sclerosis? Explain:
- ☐ Musculoskeletal Disease? Explain:
- ☐ Neurological Disorder? Explain:
- ☐ Psychiatric? Explain:
- ☐ Retinal Detachment? Explain:
- ☐ Seizures? Explain:
- ☐ Skin Disorder? Explain:
- ☐ Thyroid Disease? Explain:

INSURANCE INFORMATION

There will be a $50.00 administrative fee to file insurance if not presented at the time of examination.

Name of Primary Insured _____ Birth Date of Insured _____

Insurance Company _____ Insurance ID _____ Last 4 digits of SSN _____

PLEASE PRESENT YOUR MAJOR MEDICAL INSURANCE CARD AT TIME OF SERVICE

☐ I give Boulder Vision Associates permission to bill my insurance for services and products related to my vision care. They are authorized to share information about my eye care, diagnoses, and treatments with my insurance for billing purposes. I agree to pay for any services, products, and procedures not covered by my insurance. In the event that my insurance is canceled or denied, I agree to pay for all services, products, and procedures within 30 days of my claim rejection. I will assume responsibility for reimbursement from my provider should I disagree with their denial of my claim.

Please check the following methods that we may contact you about your appointment, test results, insurance coverage, eyeglasses, and/or contact lens orders:

☐ Mail ☐ Telephone ☐ Text Message ☐ Email Today's Date _____

Signature (please sign at office): _____ Submit by E-mail