Patient Intake Form

Patient Information

Last Name: _____ First Name: _____ DOB:_____

Address: _____ SSN #: _____

Sex: _____ Home Phone: _____ Mobile Phone: _____

Preferred Phone: Home or Mobile (circle one) Email: _____

Marital Status:_____ Employer: _____

Occupation: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone: _____

Primary Doctor (PCP): _____ PCP Phone: _____

Preferred Pharmacy: _____

Please list ALL active treating physicians (i.e. pulmonologist, oncologist, internist, cardiologist, etc.…)

Doctor's Name: _____ Specialty: _____

Doctor's Name: _____ Specialty: _____

Patient Financial Obligation Agreement

I understand that all applicable copayments and deductibles are due at the time of service. I agree to be financially responsible and make full payment for all charges not covered by my insurance company. I authorize my insurance benefits be paid directly to Clear View Vision Center for services rendered. I authorize representative of Clear View Vision Center to release pertinent medial information to my insurance company when requested or to facilitate payment of a claim.

Information Disclosure and Consent

Clear View Vision Center will provide you with the health plans that your provider(s) accepts. If you decide to be treated by a provider who does not accept your health plan, you will be asked to sign a consent form agreeing that you accept treatment from that provider.

I read and agree to all of the above information.

Patient or Legal Guardian Name (Print):_____

Patient or Legal Guardian Signature:_____ Date:_____

Continue to backside →

Please **PROVIDE** a list of all your current medications (or continue to write them out), including over the counter medications, supplements, and herbs:

Medication Name	Dose

Medication Name	Dose

Do you have any allergies to medications or other substance (pets, food, etc.)? Y N

If yes, please list allergies and reaction (including rash, hives, throat swelling, anaphylaxis):

Allergy	Reaction

Allergy	Reaction

General Medical Questionnaire

Have you EVER had any of the following?

Blindness ..... Y N

Arthritis..... Y N

Cataract..... Y N

Glaucoma..... Y N

Macular Degeneration..... Y N

Retinal Detachment/Disease..... Y N

Cancer..... Y N

Crossed Eyes..... Y N

Heart Disease/Disorder..... Y N

Lung Disorder..... Y N

High Blood Pressure..... Y N

Neurological Disorder/Chronic Headaches... Y N

Diabetes..... Y N

Thyroid Disorder..... Y N

Stroke..... Y N

Please indicate any major conditions/illnesses that your immediate family members have had:

Relative	**Health and/or Eye Conditions:**
Mother	
Father	
Sibling	
Other:	

Do you currently smoke? Y N If no, previously? Y N Years smoked_____ Packs/day_____

Do you use other tobacco products? Y N Consume alcohol? Y N If yes, drinks/week: _____

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