VITA EYE CLINIC
EYE EXAMS • OCULAR DISEASE • RESEARCH

Thank you for choosing Vita Eye Clinic. Privately owned and operated since 2016, we strive to give you an enhanced eye care experience. Please take a moment to fill out the intake form below so that we can provide you with excellent service that is tailored to your lifestyle. We think you will find that our award-winning care goes beyond your expectations. Welcome.

PATIENT INFORMATION			
Last Name:	First Name:	M.I.:	Preferred Name:
Salutation: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Other (specify):		Sex: ☐ Male ☐ Female	
Date of Birth (DOB):	Age:	Social Security Number (SSN):	
Race: ☐ American Indian ☐ Asian ☐ Black or African American ☐ White ☐ Hispanic ☐ Other (specify):		Height:	Weight:
Mailing Address:		Apt #:	
City/State/Zip:		E-mail:	
Home Phone:	Cell Phone:	Work Phone:	
Preferred Method of Contact for Reminder Calls and Other Electronically Generated Messages: (Please select only one option): ☐ Voice ☐ Text ☐ E-mail		If Voice, Please Select Preferred Number: ☐ Home ☐ Cell ☐ Work	
Occupation:	Employer Name:		
Name of Emergency Contact:	Relationship of Emergency Contact to Patient:	Emergency Contact Phone Number(s): ☐ Home: ☐ Cell:	
Family Physician or Pediatrician:	Referring Phyiscian:		
Preferred Language: ☐ English ☐ Spanish ☐ Other (specify):	Preferred Pharmacy Name and Location:		
How did you hear about us?			

RESPONSIBLE PARTY - **If** the patient is a minor (under the age 18), the partent or gaurdian bringing the patient in will be listed as the guarantor.			
Last Name:	First Name:	M.I.:	Sex: ☐ Male ☐ Female
Mailing Address of Person Responsible:			Apt #:
City/State/Zip:			Date of Birth (DOB):
Phone: ☐ Home ☐ Cell ☐ Work	E-mail:		Relationship to Patient:

MEDICATIONS - List all medications you take, prescription and non-prescription with dosage (if known). ☐ **I do not take any medications**	
Medication Name:	**Dosage (if known):**
List current eye drops: ☐ N/A	

ALLERGIES - Medication and Food Allergies (list all known allergies):	☐ **No known allergies**

MEDICAL HISTORY - Check if you have ever experienced any of the following conditions and write in year of onset.			
Condition:	**Year:**	**Condition:**	**Year:**
☐ None		☐ Heart Attack	
☐ Allergies		☐ Hepatitis C	
☐ Anemia		☐ High Cholesterol	
☐ Angina		☐ High Blood Pressure	
☐ Anxiety		☐ Irritable Bowel Syndrome	
☐ Arthritis		☐ Liver Disease	
☐ Asthma		☐ Lupus	
☐ Atrial Fibrillation		☐ Migraine Headaches	
☐ Benign Prostatic Hypertrophy		☐ Multiple Sclerosis	
☐ Blood Clots		☐ Myasthenia Gravis	
☐ Cancer, Type:		☐ Osteoarthritis	
☐ Stroke		☐ Osteoporosis	
☐ Coronary Artery Disease		☐ Peptic Ulcer Disease	
☐ COPD		☐ Rheumatoid Arthritis	
☐ Crohn's Disease		☐ Renal Disease	
☐ Depression		☐ Seizure Disorder	
☐ Diabetes		☐ Thyroid Disease	
☐ Gallbladder Disease		☐ Other:	
☐ GERD		☐ Other:	
Are you pregnant? ☐ N/A ☐ Yes ☐ No		Are you nursing? ☐ N/A	☐ Yes ☐ No

SURGICAL HISTORY	☐ **No prior surgeries**
Surgery:	Year:

FAMILY HISTORY - Check if any family member(s) have had any of the following conditions:		☐ **None** ☐ **Adopted**	
Diagnosis/Condition:	**Family Member:**	**Diagnosis/Condition:**	**Family Member:**
☐ Alcoholism	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ _____	☐ Heart Attack	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ _____
☐ Allergies	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ _____	☐ High Cholesterol	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ _____
☐ Alzheimer's Dementia	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ _____	☐ High Blood Pressure	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ _____
☐ Asthma	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ _____	☐ Irritable Bowel Syndrome	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ _____
☐ Blood Disease	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ _____	☐ Learning Disability	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ _____
☐ Coronary Artery Disease	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ _____	☐ Mental Illness	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ _____
☐ Cancer, Type:	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ _____	☐ Tuberculosis	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ _____
☐ Stroke	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ _____	☐ Obesity	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ _____
☐ Depression	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ _____	☐ Osteoarthritis	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ _____
☐ Developmental Delay	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ _____	☐ Osteoporosis	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ _____
☐ Diabetes	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ _____	☐ Peripheral Vascular Disease	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ _____
☐ Eczema	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ _____	☐ Renal/Kidney Disease	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ _____
☐ Hearing Deficiency	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ _____	☐ Other:	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ _____

Check if any family member(s) have had any of the following conditions:		☐ **None** ☐ **Adopted**	
Diagnosis/Condition:	**Family Member:**	**Diagnosis/Condition:**	**Family Member:**
☐ Amblyopia	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ _____	☐ Macular Degeneration	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ _____
☐ Cataracts	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ _____	☐ Strabismus	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ _____
☐ Glaucoma	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ _____	☐ Other:	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ _____

OCULAR HISTORY			
Purpose of Today's Visit:			
☐ Blurred Vision	☐ Grittiness		☐ Eye Pain
☐ Double Vision	☐ Headaches		☐ Annual/Comprehensive Exam
☐ Dryness	☐ Infection		☐ Watery Eyes/Tearing
☐ Flashes of Light	☐ Itchiness		☐ Update Contact Lenses
☐ Floaters/Spots in Vision	☐ Night Vision Difficulty		☐ Update Glasses/Frames
Which eye has the problem? (Circle one) Right Eye Left Eye Both Eyes		**Is it new, ongoing or returning?** (Circle one) New Ongoing Returning	
How is it affecting you? (Circle one) Bothersome Aware Painful		**How severe is the problem:** (Circle one) Mild Moderate Severe	
How long have you had the problem?		**Are there associated symptoms?**	
Have you previously been diagnosed with any of the following? ☐			
☐ Allergies	☐ Eye Infection		☐ Loss of Vision
☐ Cataracts	☐ Floaters		☐ Macular Degeneration
☐ Color Blindness	☐ Glare / Light Sensitivity		☐ Retinal Detachment
☐ Corneal Abrasion	☐ Glaucoma		☐ Strabismus (Crossed Eyes)
☐ Diabetic Retinopathy	☐ Herpetic Eye Disease		☐ Ulcer
☐ Dry Eye	☐ Iritis/Uveitis		☐ Other:
When was your last eye exam? ☐ Unknown	List any prior eye surgeries and dates if known (e.g. LASIK, cataract surgery):		
Do you currently wear glasses? ☐ Yes ☐ No	If you selected yes to currently wearing glasses, what type of lens are in your glasses? ☐ Single Vision ☐ Bifocal ☐ Trifocal ☐ Progressive (No-line) ☐ Unknown		
Do you currently wear contact lenses? ☐ Yes ☐ No If no, skip to the next section.	What type of contacts do you wear? ☐ Soft ☐ Rigid	What is the manufacturer/model of your contact lenses?	
If known, please provide the power of your contact lenses:	How old are your current contact lenses?	How often do you replace your contact lenses?	
Which solution(s) do you use to care for your contact lenses? ☐ Renu ☐ Optifree ☐ Clear Care ☐ Boston Advance ☐ Boston Simplicity ☐ Optimum ☐ Other:			

Please Read, Initial and Sign:

AUTHORIZATION TO RELEASE INFORMATION AND OFFICE POLICY ON PAYMENT: I assign all of my medical benefits to VITA EYE CLINIC and authorize said assignee to release all information necessary to secure payment from my insurance company. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company, and that final determination can only be made when the claim is processed. As such, I understand that if some fees are not paid by my insurance, I am still responsible and will be billed for them. Accounts 90 days-old are subject to collections, and there will be a service charge for any bounced checks. In order to control billing costs and reduce the need to raise our fees, all co-payments, deductibles, and charges for non-covered services, as per my insurance contract, are due at the time that they are rendered. ____ (Initial)

CONSENT FOR TREATMENT: I/We hereby authorize VITA EYE CLINIC to administer diagnostic and medical procedures as may be necessary for proper health care. ____ (Initial)

VISION PLAN COVERAGE: I/We understand that only one vision plan may be used for exam/materials per visit - per patient and that the vision plan to be used must be chosen before the exam occurs and can not change at a later date. ____ (Initial)

_____ _____

Signature Date

_____ _____

Responsible Party's Signature Date

Health-Related Communications & Reminders by Mobile Telephone Texting & E-Mail:
I permit VITA EYE CLINIC to communicate & remind me about my health-related issues & appointments by texting & e-mail.

_____ _____

Signature Date

If you would like anyone to have information on your eye health, please give their name and specify your relationship below:

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____