Patient Name (First, MI, Last)_____

Mailing Address_____

City_____ State_____ Zip Code_____

Primary Phone:_____ Secondary Phone:_____

Date of Birth____/____/____ SSN ____-____-_____ Email_____

Employer_____ Occupation_____

Sex: Male / Female Race:_____ Preferred Language:_____

Are you a smoker? **Yes / No / Former** Do you drink alcohol? **Yes / No** Marital Status:_____

Are you a new patient? _____ Date of last exam:_____ Current Eyewear: **Glasses/Contacts**

If you wear Contacts, what brand?_____ Are you interested in contact lenses? **Yes / No**

Current eye drops? _____ Primary Care Physician: _____

Please list all medications_____

_____

Please list all drug allergies _____

Reason for your visit today _____

Medical History

Of the selections below please circle all that applies to you and or your immediate family members (*Parents*, *Siblings and Children*) and then specify who has the condition

Constituion:

Fatigue Syndrome Developmental Disabilities Cancer Who:_____

Ear, Nose and Throat:

Sinusitis Dry Mouth Laryngitis Hearing Loss Who:_____

Neurological:

Migraine Multiple Sclerosis Cerebral Palsy Stroke/CVA Tumor Who:_____

Psychiatric:

Anxiety Disorder Depression Bipolar Disorder Attention Deficit Who:_____

Cardiovascular:

Vascular Disease Heart Disease Congestive Heart Failure Hypertension Who:_____

Respiratory:

Chronic Obstruction Bronchitis Asthma Emphysema Sleep Apnea Cigarette Smoker Who:_____

Gastrointestinal:

Colitis Acid Reflux Crohn's Ulcer Celiac Disease Who:_____

Genitourinary:

STD'S Pregnant Nursing Benign Prostate Hypertrophy Who:_____

Musculoskeletal:

Muscular Dystrophy Osteoporosis Gout Osteoarthritis Fibromyalgia Arthritis Who:_____

Integumentary:

Eczema Psoriasis Rosacea Cold Sores Shingles Who:_____

Endocrine:

Thyroid Dysfunction Hormonal Dysfunction Type 1 Diabetes Type 2 Diabetes Who:_____

Hemotologic / Lymphatic:

Hypercholesteremia Large-Volume Blood Loss Anemia Who:_____

Allergic/ Immune:

Lupus Rheumatoid Arthritis Sjogren's Syndrome Who:_____

Ocular History:

Cataracts Macular Degeneration Glaucoma Dry Eye Other:_____ Who:_____

With my signature, I authorize treatment by Asheville Vision Associates and staff. I understand I am financially responsible for all charges and any services rendered, including, if applicable, the balance remaining after possible insurance benefits. I understand the benefits quoted from my insurance company is not a guarantee of payment. I authorize the release of any medical information necessary to process my insurance claim. I assign and request that insurance payment be made directly to Asheville Vision Associates. I further acknowledge that I have read their Notice of Privacy Practices, been offered a copy and authorize the staff to communicate by mail or phone. PLEASE NOTE THAT ALL ACCOUNTS NOT PAID WITHIN 30 DAYS ARE CONSIDERED DELINQUENT AND WILL HAVE AN ADDITIONAL CHARGE OF $15.OO

Signature_____ Date_____ (Required)

Responsible party (if under the age of 18):

Name_____ D.O. B ___/___/____ SSN_____

********** FOR OFFICE USE ONLY**********

Appointment/Walkin Time:_____

Vision Ins:_____ Medical Ins:_____

B/P_____ Height_____ Weight_____