PATIENT INFORMATION

NAME: _____ BIRTH DATE: _____

ADDRESS: _____

CITY :_____ STATE :_____ ZIP CODE :_____

CELL PHONE NUMBER: _____ HOME PHONE NUMBER: _____

EMAIL: _____

MEDICAL & OCULAR HISTORY

DO YOU OR ANY OF YOUR CLOSE RELATIVES HAVE ANY OF THESE CONDITIONS?

	SELF	RELATIVE	RELATIONSHIP
❖ ASTHMA	☐	☐	_____
❖ CATARACTS	☐	☐	_____
❖ DIABETES	☐	☐	_____
❖ DRY EYES	☐	☐	_____
❖ GLAUCOMA	☐	☐	_____
❖ HIGH CHOLESTEROL	☐	☐	_____
❖ HYPERTENSION	☐	☐	_____
❖ MACULAR DEGENERATION	☐	☐	_____
❖ RETINAL DETACHMENT	☐	☐	_____
❖ PAST EYE SURGERY	☐	☐	_____
❖ CURRENTLY TAKING PLAQUENIL?			Yes No

HIPAA NOTICE OF PRIVACY PRACTICES

I HEREBY ACKNOWLEDGE THAT A COPY OF THE PRIVACY PRACTICES OF VELD VISION CENTER HAS BEEN MADE AVAILABLE TO ME.

SIGN HERE _____ *DATE* _____

IF WE ARE UNABLE TO SPEAK WITH YOU DIRECTLY REGARDING MATTERS PERTAINING TO YOUR CARE, THIS INFORMATION MAY BE RELEASED TO:

NAME _____ *PHONE #* _____

RELATIONSHIP TO PATIENT _____