VisionSource® Dr. Rachel J. Rippey & Dr. Ivan O. Velazquez

... Your ultimate vision providers!

WELCOME FORM

PATIENT RECORD Date: _____

FIRST NAME:	LAST NAME:	GENDER: ☐ M ☐ F	BIRTHDATE:	DAY TIME PHONE NO.:
ADDRESS: CITY: STATE: ZIP:				CELL PHONE NO:
OCCUPATION:	NAME OF EMPLOYER:	SOCIAL SECURITY NO.:	E-MAIL ADDRESS:	
VISION INSURANCE:	MEDICAL INSURANCE:	BEST WAY TO CONTACT YOU: ☐ E-mall ☐ Address Phone: ☐ DayTime ☐ Cell		
PRIMARY HOLDER OF INSURANCE: (FIRST NAME & LAST NAME)		BIRTHDATE OF PRIMARY HOLDER:	RELATIONSHIP WITH PRIMARY HOLDER :	

RACE:	HOW DID YOU HEAR ABOUT OUR OFFICE?	HAVE WE SEEN OTHER FAMILY MEMBERS?	REASON FOR TODAY'S VISIT:
☐ WHITE ☐ HISPANIC ☐ AFRICAN AMERICAN ☐ ASIAN ☐ OTHERS: _____	☐ INSURANCE ☐ OTHERS: _____ ☐ FAMILY/FRIENDS: _____ HOBBIES:	HOW MANY HOURS DO YOU SIT IN FRONT OF THE COMPUTER, TABLET, SMART PHONE? _____	☐ ANNUAL CHECK UP ☐ CONTACTS ☐ GLASSES ☐ _____

MEDICAL HISTORY

☐ DIABETES TYPE I or II	☐ HYPERTENSION	☐ THYROID PROBLEMS	☐ HIGH CHOLESTROL
OTHER MEDICAL CONDITIONS:			
IF FEMALE, CURRENTLY PREGNANT? Yes ☐ No ☐	MAJOR INJURY/SURGERY:		
☐ CATARACT	☐ GLAUCOMA	☐ DRY EYE SYNDROME	☐ FREQUENT HEADACHES
MAJOR EYE INJURY/ SURGERY:			

FAMILY'S MEDICAL HISTORY

☐ DIABETES, WHO?	☐ CATARACTS, WHO?	☐ GLAUCOMA, WHO?	☐ OTHER EYE DISEASES, WHO?

CONTACT LENS PATIENTS ☐ NOT APPLICABLE

Do you currently wear contact lenses?	Yes ☐	No ☐
Do you have any previous contact lenses experience?	Yes ☐	No ☐
Do you sleep or nap in you contact lenses?	Yes ☐	No ☐
Do your eyes become dry, itchy or irritated while wearing contacts?	Yes ☐	No ☐

Type of lenses worn: ☐ Soft ☐ Gas Permeable/Hard ☐ Toric (Astigmatism) ☐ Bifocal ☐ Daily ☐ Extended Wear

Present contact lenses:

Brand: Solutions: Re-wetting drops: _____

I certify that the above information is true and accurate to the best of my knowledge.

Signature: _____ Relationship to Patient: _____

FIRST NAME:_____ LAST NAME:_____ DOB: _____

TOBACCO USE: ☐ FORMER SMOKER ☐ NEVER SMOKED ☐ CURRENT SMOKER

LAST COMPLETE EYE EXAM: ☐ First Complete Eye Exam Today

DOCTOR:_____ LOCATION:_____ LAST VISIT: _____

ARE YOU UNDER CARE OF ANOTHER OPTOMETRIST/ OPHTHALMOLOGIST? ☐ Yes ☐ No

DOCTOR: _____ LOCATION:_____ LAST VISIT: _____

PHONE NO.:_____ FAX NO.:_____ REASON: _____

DO YOU NEED A REPORT OF YOUR VISIT FAXED TO ANOTHER DOCTOR? ☐ Yes ☐ No

IF YES: ☐ To the same doctor above. ☐ To the doctor below:

DOCTOR:_____ LOCATION:_____ LAST VISIT: _____

PHONE NO.:_____ FAX NO.:_____ REASON: _____

YOUR PHARMACY INFORMATION:

NAME OF PHARMACY:_____ PHONE NO. _____

ADDRESS: _____

LIST OF ORAL AND OCULAR MEDICATIONS:

NAME	PURPOSE

NAME	PURPOSE

ALLERGIES: ☐ No Known Drug Allergies

☐ Penicillin ☐ Sulfa Drugs ☐ Codeine ☐ Steroids ☐ Latex ☐ Seasonal allergies

☐ Other Medications: _____

Assignment of Benefit & Signature on File

I certify that the above information is true and accurate to the best of my knowledge. I authorize the release of my medical or other information necessary to process insurance claims. A copy of complete privacy notice is displayed in the office and is available upon request. I also authorize payment of benefits to the physician who performed the services. I understand insurances only provide a quote of benefit to my healthcare provider and do not guarantee payment. I understand that the payment of the claim will not be determined until the actual claim is received, and I may be responsible for different charges I paid upon the date of service according to the insurance company.

Signature:_____ Relationship to Patient: _____