

VISION PLUS

New Patient Health Questionnaire and Registration

Providers: Kris E. Smith, O.D. | Kori Watkins, O.D. | Craig S. Horner, O.D.

1) Patient Information

Patient Full Name: _____ Date: _____

Date of Birth: _____ Sex: _____ Marital Status: _____

Primary Address: _____

City: _____ State: _____ ZIP: _____

Primary Phone: _____ Cell Phone: _____

Email Address: _____

Employer: _____ Employer Phone: _____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Phone: _____

Preferred method for appointment reminders/results: Phone Call Text Email Patient Portal (if available)

2) Referral Source

How did you hear about us?

Internet Search Our Website Insurance Company Radio Newspaper Other: _____

Referred by: Friend/Family: _____

Primary Care Physician (Name): _____ Optometrist/Ophthalmologist (Name): _____

3) Vision and Eye History

Do you wear glasses? Yes No If yes, age of current pair: _____

Do you wear contact lenses? Yes No If yes: Soft Disposable RGP Other: _____

Contact lens brand (if known): _____ Age of current lenses: _____

Are you interested in a contact lens prescription today? Yes No

Are you currently having problems with your vision, glasses, or contact lenses? Yes No

If yes, explain: _____

Have your eyes ever been dilated? Yes No If yes, any prior issues? _____

4) Personal Medical and Ocular History

(Please check Yes, No, or Currently where applicable)

Note: "Currently" means active now or within the past 3 months.

Condition	Yes	No	Currently
Pregnant / Nursing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye injuries / trauma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Head trauma / Concussion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye surgery (including cataract/LASIK)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Retinal disease / retinal detachment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Lazy eye / crossed eyes / droopy lids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Double vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flashes / floaters / spots in vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes (Type 1 or Type 2)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease / heart attack / stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches / migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other significant medical conditions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If "Yes" or "Currently" to any above, please explain (include year diagnosed if known): _____

Current medications (including eye drops): _____

Drug allergies / reactions: _____

Primary Care Physician: _____ Last visit date (if known): _____

5) Family History

Has any blood relative been diagnosed with:

Condition	Yes	No
Blindness	<input type="checkbox"/>	<input type="checkbox"/>
Cataract	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Macular degeneration	<input type="checkbox"/>	<input type="checkbox"/>
Retinal disease / retinal detachment	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Autoimmune disease (e.g., lupus, rheumatoid arthritis)	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>

Details:

6) Social History

Do you drive? Yes No

Do you experience visual difficulty while driving? Yes No

If yes, explain: _____

Tobacco use: Never Former Current Alcohol use: None Occasional Regular

Recreational drug use: No Yes (optional details): _____

7) Review of Systems (ROS)

Are you currently experiencing symptoms in any of these areas?

- Constitutional (fever, weight change)
- Ear/Nose/Throat (sinus, allergies, chronic cough)
- Neurologic (headaches, migraines, seizures)
- Respiratory (asthma, bronchitis, emphysema)
- Cardiovascular/Vascular (heart pain, HTN, vascular disease)
- Gastrointestinal
- Genitourinary
- Musculoskeletal (joint/muscle pain, arthritis)
- Endocrine (thyroid/other glands)
- Hematologic/Lymphatic (anemia, bleeding problems)
- Allergic/Immunologic
- Psychiatric
- Eye symptoms (blurred vision, redness, dryness, pain, light sensitivity, flashes/floaters, etc.)

If any boxes are checked, please describe:

8) Consents and Acknowledgments

A. Consent to Evaluation and Treatment

I consent to eye care services, including examinations and medically appropriate diagnostic testing.

Patient/Guardian Signature: _____ Date: _____

B. Assignment of Benefits and Release of Information

I authorize payment of insurance benefits (including Medicare when applicable) directly to Vision Plus/providers for covered services.

I authorize release of medical information necessary to process claims and coordinate care, as permitted by law.

Patient/Guardian Signature: _____ Date: _____

C. Financial Responsibility Acknowledgment

I understand I am responsible for co-pays, deductibles, non-covered services, refraction/contact lens fees, and any balance not paid by insurance.

Patient/Guardian Signature: _____ Date: _____

D. HIPAA Notice of Privacy Practices (NPP)

I acknowledge I have been offered/provided Vision Plus's Notice of Privacy Practices.

Patient/Guardian Signature: _____ Date: _____

Person(s) who may receive PHI (Protected Health Information) on my behalf:

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

If patient declines to sign, staff initials: _____ Date: _____ Reason: _____

E. Communication Consent

Vision Plus may contact me regarding appointments, care coordination, and billing by the methods I selected above. I understand I may update preferences at any time.

Patient/Guardian Signature: _____ Date: _____

F. Media Consent

I give Vision Plus permission to use photos, video and/or comments by me for promotional purposes including Social Media, the website and other marketing materials. Yes No

Patient/Guardian Signature: _____ Date: _____

9) Office Use Only

History reviewed and updated by provider/staff: _____ Date: _____

Changes noted from prior history: N/A Yes (documented in chart)

Provider Signature: _____ Date: _____