FAMILY VISION OF OREGON, P.C.

1864 Columbia Blvd., St. Helens, OR 97051 (503)397-2020 FAX (503)397-7701
51675 N. Columbia River Hwy., Scappoose, OR 97056 (503)543-6313 FAX (503)543-6349

PATIENT INFORMATION

Last name:____________________
First name:________________M.I.________

Date of birth:________________Gender: M F
Mailing address:____________________
City:__________State:______Zip:________

Home phone:____________________
Work phone:____________________
Cell phone:____________________
Email address:____________________

Preferred language:____________________
Race:____________________
Ethnicity:____________________

Patient's SSN:____________________
Employer (or school):____________________
Occupation (or grade):____________________

May we leave detailed voice messages on your phone? YES NO

May we email you with appointment confirmations or other reminders? YES NO

May we text you with appointment confirmations or other reminders? YES NO

Spouse (or guardian's) name:________________
Spouse (or guardian's) employer:________________

NOTICE OF PRIVACY PRACTICES

In the course of providing services to you, we create, receive, and store health information that identifies you. It is often necessary to use and disclose this information in order to treat you, obtain payment from insurance companies, or refer you to another physician. The full copy of the notice of privacy practices describes the uses and disclosures in detail. I acknowledge that I have received a copy of the Notice of Privacy Practices for Family Vision of Oregon, P.C.

Patient's (or guardian's) signature:

X____________________**Date:**________

INSURANCE INFORMATION

Vision Insurance:____________________
Subscriber's name:____________________
Subscriber's ID#:____________________
Subscriber's birth date:____________________

Primary Medical Insurance:____________________
Subscriber's name:____________________
Subscriber's ID#:____________________
Subscriber's birth date:____________________

FINANCIAL POLICY

Please be advised that if you are using insurance coverage for today's visit, this is a contract between you and your insurance company, not Family Vision of Oregon, P.C.

I authorize my insurance benefits to be paid directly to Family Vision of Oregon, P.C. I understand I am financially responsible for non-covered materials and services. Additionally, I authorize the doctor and staff at Family Vision of Oregon, P.C. to release any and all information required to process the claim.

I understand due to the custom nature of our products we do not offer refunds. Any modifications to your eyewear order must be made within 90 days of purchase.

Patient's (or guardian's) signature:

X____________________**Date:**________

THANK YOU FOR CHOOSING OUR OFFICE!

Whom may we thank for referring you to our office?____________________

If you were not referred, how did you choose our office?

- ☐ Another doctor
- ☐ Insurance list
- ☐ Saw sign/building
- ☐ Yellow pages
- ☐ Website

PATIENT INFORMATION

Primary Care Physician:____________________
Date of last physical:____________________
Height:______________
Weight:______________

Medications:___________________________

Allergies:___________________________

PATIENT'S MEDICAL HISTORY

Have you ever been diagnosed or treated for any of the following health problems?

	YES	NO
Allergies	☐	☐
Arthritis	☐	☐
Blood/Lymph disorders	☐	☐
Cancer	☐	☐
Cholesterol	☐	☐
Diabetes	☐	☐
Digestive disorders	☐	☐
Ear/nose/throat disorders	☐	☐
Endocrine disorders	☐	☐
Fatigue	☐	☐
Genitourinary disorders	☐	☐
High blood pressure	☐	☐
Kidney disease	☐	☐
Muscle/bone conditions	☐	☐
Neurological disorders	☐	☐
Psychological conditions	☐	☐
Respiratory conditions	☐	☐
Sinus conditions	☐	☐
Skin conditions	☐	☐
Thyroid conditions	☐	☐
Unusual weight loss/gain	☐	☐

Do you use tobacco, alcohol or other substances? ☐ ☐
If yes, what type & how often?

____

(Women only) Are you currently pregnant or nursing? ☐ ☐

HOBBIES:___________________________

SPORTS:___________________________

FAMILY HISTORY

Is there a family history of any of the following?

	Relationship:
Blindness (disease/injury)	☐__________
Cataracts	☐__________
Corneal disease	☐__________
Diabetes	☐__________
Glaucoma	☐__________
Heart disease	☐__________
High blood pressure	☐__________
Lazy eye	☐__________
Macular degeneration	☐__________
Retinal conditions	☐__________

PATIENT'S EYE HISTORY

What is the major purpose of this visit?

____

Date of last eye exam:____________________
By whom?____________________
Current glasses/contacts:____________________

Have you ever experienced, been diagnosed with or treated for any of the following?

- ☐ Blurry vision
- ☐ Burning
- ☐ Cataracts
- ☐ Corneal abrasion
- ☐ Crossed eye/eye turn
- ☐ Double vision
- ☐ Dry eyes
- ☐ Eye infections
- ☐ Eye injury
- ☐ Floaters/flashes
- ☐ Glaucoma
- ☐ Headaches
- ☐ Iritis/uveitis
- ☐ Itching of the eyes
- ☐ Lazy eye/amblyopia
- ☐ Light sensitivity
- ☐ Macular degeneration
- ☐ Retinal detachment
- ☐ Tearing/watering of eyes
- ☐ Other eye conditions:____________________
- ☐ Eye surgeries:____________________

OCCUPATIONAL VISION NEEDS/REQUIREMENTS (safety glasses, computer use, etc.):____________________