SUMMIT
VISION SOURCE

Patient Information

Name: _____ Date of Birth: _____ Gender: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Phone (Cell/Home/Work): _____

Email Address: _____ Social Security Number: _____

Employer: _____ Occupation: _____

Medical Insurance Provider: _____ Member ID: _____

Vision Insurance Provider: _____ Member ID: _____

Secondary Insurance: _____ Member ID: _____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Phone Number: _____

Date of last eye exam: _____ Reason for visit today: _____

What are your visual symptoms? (Circle all that apply)

| | | | |
|---|---|---|---|
| Blurry Distance Vision | Burning Eyes | Floaters or Spots | Headaches |
| Blurry Near Vision | Itchy Eyes | Seeing Flashes | Migrain Headaches |
| Double Vision | Eye Injury | Dry Eyes | Poor Night Vision |
| Crossed/Turned Eyes | Eye Strain | Red Eyes | Light Sensitivity |
| Eye Infection | Watery Eyes | Lid Pain | Sandy/Gritty Feeling |

Do you wear glasses? _____ If yes, when do you wear them? All the time Reading Working Driving

Do you wear contact lenses? _____ If yes, what type/brand: _____

Personal Medical Information

Do you have any eye conditions or problems? _____ If yes, what kind: _____

Have you had any eye operations? _____ If yes, what type and date: _____

Have you had an eye injury? _____ If yes, what type and date: _____

List all current medications (or provide list): _____

Any allergies? _____ If yes, please list: _____

Are you pregnant? _____ Are you nursing? _____ Are you trying to get pregnant? _____

Do you smoke? _____ Do you drink alcohol? _____ Do you use recreational drugs? _____

Have you or a family member been diagnosed with any of the following: (Please write who was diagnosed)

Glaucoma _____ Cataracts _____ Eye Surgery _____

Diabetes _____ Macular Degeneration _____ Retinal Detachment _____

Heart Disease _____ High Blood Pressure _____ Crossed/Lazy Eye _____

Arthritis _____ Multiple Sclerosis _____ Asthma _____

Cancer _____ Other Eye Disease _____ Other _____

I give permission for the following person(s)at access my account and medical records:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

We respect HIPAA to keep your health information private.

_____ _____

Patients Signature or Patient's Legal Representative Date