HindSight

# Patient Intake Form

| Last Name | First Name | Middle |
|---|---|---|
| Birth Date | Sex: M F | Email |
| Street Address | City | State / Zip |
| Phone | Second Phone | |
| Employer | Occupation | |
| Primary Insurance Company | Phone ( ) | |
| Policy Name / ID # | D.O.B. If Required | |
| Secondary Insurance Company Name | Phone | |
| Secondary Policy Name / ID # | D.O.B. If Required | |
| Emergency Contact | Cell Phone ( ) | |
| Primary Care Physician: | Alt Phone ( ) | |
| Do you wear sunglasses? Yes No | Do your eyes strain from computers? Yes No | Do you smoke? Yes No |

## Medical History: *Please check if you have been **diagnosed with or treated for** the following.*

| Diagnosed | Yes✓ | Diagnosed | Yes✓ |
|---|---|---|---|
| Arthritis | | High Cholesterol | |
| Cancer | | HIV | |
| Cataracts | | Loss Of Balance/Falls | |
| Diabetes | | Macular Degeneration | |
| Eye Surgeries | | Pregnant or Nursing | |
| Flashing Lights | | Pulmonary Disease | |
| Glaucoma | | Retinal Detachment | |
| Headaches/Migraines | | Thyroid Problems | |
| Heart Disease | | Vertigo | |
| Hepatitis | | Vision Loss or Change In Vision | |
| High Blood Pressure | | Visual Spots | |

| Medication/Prescription Over the counter | Dosage MG | Frequency #Times/ Day | Reason/ Condition Treated | Prescribing Doctor |
|---|---|---|---|---|
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I understand that under The Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information.

Patient Signature:_____Date:_____