VISIONARIES EYECARE
400 S. Main · Hutchinson, KS 67501
Phone: 620-500-2020 Fax: 620-615-7075

General Information: Today's date: _____

Name: _____ Date of Birth: _____

Nickname: _____ Gender: _____ Last 4 of SSN: _____

Address: _____ City, State, Zip Code: _____

Primary phone: _____ cell / home / work
Would you like to receive text message reminders and order notifications: Yes / No

Secondary Phone: _____ cell / home / work / other: _____

Occupation: _____ Employer: _____ Primary care physician: _____

Email: _____ Insurance: _____
**Would you like to be enrolled in our patient portal? Yes / No

If under 18 please provide parents' names: _____

Emergency contact: _____ Relationship: _____ Phone: _____

Your Family's Medical History:
Has anyone in your <u>immediate family</u> ever been diagnosed with any of the following?
If yes, please state relationship.

Glaucoma	Y N _____	High Blood Pressure	Y N _____
Macular Degeneration	Y N _____	Diabetes	Y N _____
Retinal Detachment	Y N _____	Arthritis	Y N _____
Cancer	Y N _____	Thyroid Disorder	Y N _____

Name: _____ DOB: _____

Your Medical History:
Do you currently or have you previously had any problems in the following areas?
If yes, please explain.

Systemic:	**Circle**	**Explanation**
Cancer	Yes / No	_____
Migraines	Yes / No	_____
Multiple Sclerosis	Yes / No	_____
Anxiety	Yes / No	_____
Depression	Yes / No	_____
Asthma/Bronchitis	Yes / No	_____
Hypertension	Yes / No	_____
Heart Disease	Yes / No	_____
Stroke	Yes / No	_____
Crohn's Disease	Yes / No	_____
Kidney Disease	Yes / No	_____
Gout	Yes / No	_____
Arthritis	Yes / No	_____
Eczema/ Rosacea	Yes / No	_____
Anemia	Yes / No	_____

Systemic:	**Circle**	**Explanation**
Diabetes	Yes / No	_____
Thyroid Issues	Yes / No	_____
Lupus	Yes / No	_____
Seasonal Allergies:	Yes / No	_____

Ocular:	**Circle**	**Explanation**
Glaucoma	Yes / No	_____
Cataracts	Yes / No	_____
Retinal Detachment	Yes / No	_____
Age Related Macular Degeneration	Yes / No	_____

Other Medical Diagnoses:

_____ _____

_____ _____

Allergies and Reactions (to medication or otherwise)

_____ _____

_____ _____

Current Wearer of: Glasses / Contacts / Neither / Interested in contacts

Medications and Dosage (mg)

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Surgical History

Procedure	Date	Doctor
_____	_____	_____
_____	_____	_____
_____	_____	_____

Social History:

Do you use Tobacco: Yes / No / Formerly :If Yes/Formerly please explain: _____

Do you consume Caffeine: Yes / No / Formerly Do you consume Alcohol: Yes / No / Formerly

Name: _____ DOB: _____

Authorization to Disclose Information

I authorize and consent the release of information including:

☐ Diagnosis ☐ Procedures ☐ Appointment details ☐ Whole Chart

Significant Other: _____

Child(ren): _____

Other: _____

☐ Declined to release information to anyone.

I authorize the release of any medical information to process all claims, and request payment of any medical benefit to Visionaries Eyecare.

I acknowledge I have received a copy of Visionaries Eyecare, Notice of Privacy Practices.

_____ _____

Patient signature Date

Where did you hear about us:

Billboard Facebook Google Word of Mouth Other: _____