FORT PIERCE VISION CARE

BLACK INK ONLY

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828 SOUTH US HIGHWAY 1,
FORT PIERCE, FL, 34950

PATIENT INFORMATION (PLEASE PRINT)

CIRCLE ONE

Name: ________________________________ **MALE/FEMALE** Birth Date: ______________ Age: ____
If Married, Name of Spouse: ___________________ If Child, Parent's Name: ____________________
Address: ____ Apt. #: ____________
City: ___________________ State: ______ Zip Code: _____________
Occupation: ___________________________________ SS#:___________________________
Primary Phone #: _______________________ Secondary Phone #: ________________________
Emergency Contact: __________________________________ Phone#_____________________

PLEASE CHECK THE REASON FOR TODAY'S EYE EXAM:

☐ Eye Exam ☐ Exam & Glasses ☐ Exam & Contacts ☐ Exam, Glasses & Contacts
Other**:** ____

Last Complete Eye Exam: ________________ By Doctor: ________________________
Last Physical Exam: __________________ By Primary Doctor: _____________________

PLEASE CHECK ONLY ITEMS THAT APPLY

Do you or any close blood relative have any history of the following conditions?

	Self	Family
Arthritis	____	____
Diabetes	____	____
Heart Disease	____	____
High Blood Pressure	____	____
Thyroid Disease	____	____
Lung/Breathing	____	____
Cancer	____	____
Cataract	____	____
Turned/Lazy Eye	____	____
Blindness	____	____
Kidney Disease	____	____
Sinus Problems	____	____
Other Eye Disease	____	____
Glaucoma	____	____

Do you **presently** have any of these conditions:

Blurred vision	____
Hay fever/Sinus	____
Pregnant	____
Eye injury	____
Eye surgery	____
Stroke	____
MEDICAL COND. RELATED TO EYES:	
Headache	____
Red Eyes	____
Eyes Water	____
Eyes Itch	____
Floaters	____
Light Sensitive	____
Flashes of Light	____
Eye Lid Problems	____

List any other medical conditions: ____
Please list all allergies: ____
Please list all medications: ____
____
____

About Patient Authorization:
I authorize the release of any medical or other information necessary to process this claim and determine benefits payable for related services. I also request payment of government or insurance benefits, to either myself or on my behalf, to Dr. Moll for any services furnished to me by Dr. Moll. I grant Dr. Moll my permission to provide the necessary medical treatment. I have received and read Fort Pierce Vision Care's notice of privacy practices.
Patient Signature: ____ Date: _________________
(Or parent/legal guardian if patient is a minor.)