Fort Pierce Vision Care

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PATIENT INFORMATION (Please Print)

LAST ↓ FIRST ↓ M. I. ↓ CIRCLE ONE ↓

Name_____ **MALE/FEMALE** Birth Date_____ Age _____
If Married, Name of Spouse _____ If Child, Parents Name _____
Address _____ Apt # _____
City _____ State _____ Zip _____ Primary Phone _____
Occupation _____ Secondary Phone _____
SS#_____
Person to contact in case of emergency _____ Phone # _____
➔ **Reason for today's eye exam:** _____
Last complete eye exam _____ By Doctor _____
Last physical exam _____ By Doctor _____

PLEASE CHECK ONLY ITEMS THAT APPLY

Do you or any close blood relatives 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	_____
Double Vision	_____
Eyes Water	_____
Eyes Itch	_____
Floaters	_____
Light Sensitive	_____
Flashes of Light	_____
Eye Lid Problems	_____
Red Eyes	_____

List of other medical conditions _____

Please list all allergies _____
Please list all medications _____
_____
_____

Have you ever worn contact lenses? Yes No
If yes, what type? Soft Hard Brand Name?_____
Are you interested in contact lenses? Yes No Colored contacts? Yes No

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.
Lifetime Patient Signature_____ Date _____
(Or parent/legal guardian if patient is a minor)