WELCOME TO BALLARD VISION ASSOCIATES

TODAY'S DATE: _____ / _____ / ______

PATIENT INFORMATION

Patient Name: ______________________________ Preferred Name?____________________
Address: ______________________________ City: ____________________ State: _____ Zip: ______________
Date of Birth: ____ / ____ / _____ Age: ____ Social Security #: _____-_____-______ Sex: [ ] Male [ ] Female
Phone: Home: ________________________ Work: ________________________ Cell: ________________________
E-mail Address: ______________________________(Kept absolutely confidential-used only for appt. reminders, etc.)
Occupation: ______________________________ Employer: ________________________________
Marital Status: [ ]Single [ ]Married [ ]Divorced [ ]Widowed
Spouse's Name: ____________________ Occupation: __________________ Employer: ____________________
If Patient is a child- Name of Parent(s) Responsible:____

How did you first become aware of our practice?

[ ] Friend or Family (Name): ________________________
[ ] Medical Doctor (Name): ________________________
[ ] Insurance Company
[ ] Practice Website
[ ] Internet Search Engine
[ ] Drive By
[ ] Direct Mail
[ ] Yellow Pages

INSURANCE INFORMATION

VISION Insurance Co.:______________________________**MEDICAL** Insurance Co.: ______________________________
Insured Member Name: ______________________________ Patient Relation to Insured:______________________
Insured Member Social Security #: ______-_____-_______ Insured Date of Birth: _____ / _____ / ______

PLEASE SIGN THE FOLLOWING STATEMENT WHICH ALLOWS DR. BALLARD TO FILE WITH YOUR INSURANCE COMPANY:
I, the undersigned, certify that I (or my dependant) have insurance coverage with the company previously listed, and assign all insurance benefits directly to Ballard Vision Associates. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature for all insurance submissions.

SIGNED: ____ **DATE:** _____ / _____ / ______

HIPPA ACKNOWLEDGEMENT: My signature below indicates that I have received, reviewed, and understand my right to privacy under HIPPA guidelines.

SIGNED: ____ **DATE:** _____ / _____ / ______

EYE HEALTH HISTORY

Date of Last Eye Exam: ____________________ Name of Eye Doctor or Location: ____

Please mark any problems below that you are currently experiencing: ☐ **NONE**

[ ] Blurred Vision- Distance
[ ] Blurred Vision- Computer
[ ] Blurred Vision- Reading
[ ] Glare at Night
[ ] Eye Strain
[ ] Headaches
[ ] Loss of Vision-intermittent
[ ] Loss of Vision-constant
[ ] Double Vision
[ ] Dry Eyes
[ ] Itchy Eyes
[ ] Burning Eyes
[ ] Red Eyes
[ ] Sandy or Gritty Sensation
[ ] Watery Eyes
[ ] Light Sensitivity
[ ] Mucous Discharge
[ ] Pain or Soreness
[ ] Flashes of Light
[ ] Floaters
[ ] Blindspot in vision
[ ] Crossed Eyes
[ ] Dizzy Spells
[ ] Eye Injury
[ ] Stye(s)
[ ] Color Vision problems
[ ] Twitching Eyelid

Do you wear glasses? [ ] Yes [ ] No [ ] Broken [ ] Lost **How old are they?** __________________

Do you wear contact lenses? [ ] Yes [ ] No **If YES**, please answer the following questions:
What Brand or Type of contact lenses do you wear?________________________ How old are your current lenses? ______________
How often do you replace your lenses?__________________ What is your normal wear schedule? _____hours/day _____days/week
What brand of solution do your lenses soak in at night?________________________

Are you having any problems with your contact lenses?[ ]Dry out easily [ ]Uncomfortable [ ]Blurry Far Vision [ ]Blurry Near Vision

***PLEASE TURN THIS FORM OVER AND COMPLETE SIDE 2 ***

EYE HEALTH HISTORY-CONTINUED

Are you interested in LASIK or other corrective surgical procedures? [ ] Yes [ ] No

Have you had LASIK or other corrective surgery? [ ] Yes [ ] No If Yes, when?_________________________

How many total hours per day do you spend at a computer?________

Please mark any of the following symptoms noticed after extended computer use:

[ ]Blurred Vision [ ]Eyestrain [ ]Dry Eyes [ ]Glare Sensitivity [ ]Headaches [ ]Neck/Backaches [ ]Distance Vision Blurred

Please mark any of the following eye diseases/conditions that apply to you OR your family(indicate which family members):

	SELF	FAMILY	WHO?		SELF	FAMILY	WHO?
Blindness	[ ]	[ ]	___________________	Macular Degeneration	[ ]	[ ]	__________________
Cataracts	[ ]	[ ]	___________________	Retinal Detachment	[ ]	[ ]	__________________
Glaucoma	[ ]	[ ]	___________________	Retinitis Pigmentosa	[ ]	[ ]	__________________
Keratoconus	[ ]	[ ]	___________________	Other Eye Disease	[ ]	[ ]	__________________

MEDICAL HISTORY

Date of Last Medical Exam: ____________________ Name of Primary Care Physician: ____

Please mark any of the following health conditions that apply to you OR your family (indicate which family members):

☐NONE

	SELF	FAMILY	WHO?		SELF	FAMILY	WHO?
Acne Rosacea	[ ]	[ ]	__________________	Hay Fever/Allergies	[ ]	[ ]	__________________
AIDS/HIV(+)	[ ]	[ ]	__________________	Heart Condition	[ ]	[ ]	__________________
Arthritis	[ ]	[ ]	__________________	Hepatitis	[ ]	[ ]	__________________
Artificial Joints	[ ]	[ ]	__________________	High Blood Pressure	[ ]	[ ]	__________________
Asthma	[ ]	[ ]	__________________	High Cholesterol	[ ]	[ ]	__________________
Bleeding Disorder	[ ]	[ ]	__________________	Kidney Disease	[ ]	[ ]	__________________
Cancer	[ ]	[ ]	__________________	Lupus	[ ]	[ ]	__________________
Depression	[ ]	[ ]	__________________	Migraine Headaches	[ ]	[ ]	__________________
Diabetes	[ ]	[ ]	__________________	Shingles	[ ]	[ ]	__________________
Emphysema	[ ]	[ ]	__________________	Skin Conditions	[ ]	[ ]	__________________
Epilepsy/Seizures	[ ]	[ ]	__________________	Stroke	[ ]	[ ]	__________________
Fibromyalgia	[ ]	[ ]	__________________	Thyroid Condition	[ ]	[ ]	__________________
Multiple Sclerosis	[ ]	[ ]	__________________	Muscular Dystrophy	[ ]	[ ]	__________________

If you have Diabetes: When were you diagnosed?______________________ What was your last A1C Level?______________________

How often do you check your blood glucose? _____________ Time of day checked:_____________ Average glucose level: __________

How long have you been treated for any other conditions listed above?____

____

Please describe any major surgeries: ____

____

Are you pregnant? _______ If YES, how many months? _____ Are you nursing? ______ Gestational Diabetes? ______

Do you smoke? ______ If YES, how many years? _____ How many packs/day? _______

CURRENT MEDICATIONS:
Include over-the-counter AND prescription drugs:
☐ NONE

____
____
____
____
____
____

ALLERGIES:
Include food AND drug allergies:
☐ NONE

____
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____
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THANK YOU!