

Welcome To VisionCare Family!

Please FAX or EMAIL this form BEFORE your appointment!

Fax: 954-434-2104 or scan/email: info@visioncarefamily.com

Mr Mrs Ms Miss Dr

Last Name: _____ First Name _____ Birthdate _____

Address: _____ City _____ State _____ Zip _____

Home ph. (____) _____ Work (____) _____ Cell(____) _____

Employer (or School) _____ Social Sec # _____

MEDICAL Insurance Name: _____ ID # _____

Main Member (if different from above) Name _____ SS# _____ DOB _____

E-mail address: (All addresses are for office use only. We are now making greater use of e-mail communication).

Referred by? Established Patient Insurance Walked in
 by my Doctor _____ by my Friend/Family _____

Medical Health

List **medications** and **dosage:**

(any over-the-counter pills, or eyedrops??)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Conditions being treated

(what **YEAR** did you start treatment??)

- for _____
 for _____
 for _____
 for _____
 for _____
 for _____

Are you currently pregnant or nursing? YES NO

Write any **ALLERGIES** (& drug allg): _____

List ALL **Surgeries** and **YEAR:** _____

Medical History

Last Medical Exam _____ Name of Physician _____

Physician Address: _____

Physician's Phone# _____ Fax# _____

Please Circle history of your systemic diseases: present or past

Vascular: Chest pain? High blood pressure? Cholesterol? Heart disease? Stroke? Arrhythmia? Murmur?

Constitutional: Weight gain? Weight loss? Nausea? Constipation? Vomit? Diarrhea? Fatigue? Fainting?

Endocrine: Diabetes? Diabetes Suspect? Thyroid dz? Gout? Crohn's? Pituitary dz?

Gastrointestinal: Acid Reflux? Gallbladder? Ulcer? Stomach/Colon cancer? Cirrhosis? Liver dz?

Genitourinary: Menopause? Kidney stones? Bladder infections? Impotence? Ovarian cysts? Prostate dz?

Ear/Nose/Throat: Sinusitis? Post Nasal Drip? Hearing Loss? Dry Mouth? Ear Infections?

Hematological/ Lymphatic: Anemia? Bleeding dz? Hodgkins? Sickle Cell? Varicose? Breast Cancer?

Immunological: HIV? Aids? Herpes simplex? Herpes zoster? Sjogren's? Lyme dz? Mononucleosis?

Skin: Acne? Psoriasis? Dermatitis? Hair Loss? Acne Rosacea? Urticaria? Impetigo? Lupus?

Musculoskeletal: Arthritis? Osteoporosis? Joint Pain? Scoliosis? Paget's? Ankylosis Spondilitis? Down's?

Neurological: Headaches? Seizure? Parkinson? MS? Nystagmus? Vertigo? Bell's Palsy? Epilepsy? Dyslexia?

Psychiatric: Depression? Anxiety? ADD? Bipolar? Insomnia? Alzheimer's? Autism? Mentally Challenged?

Respiratory: Asthma? Bronchitis? COPD? Emphysema? Lung cancer? Sarcoidosis? TB? Pneumonia?

Eye Health/Eyeglasses

Date of last EYE exam _____ Name of last EYE doctor _____

Check if you have or had any of the following eye problems?

- | | | |
|---------------------------------|-------------------------|-----------------------------|
| ___ Itching/mucous | ___ Red/Gritty/Dry eyes | ___ Infection/yellow mucous |
| ___ Blurred vision with glasses | ___ Double Vision | ___ Eye Surgery: Lasik, RK |
| ___ Trouble seeing at night | ___ Tearing/Burning | ___ Eye Injury |
| ___ Eyestrain when reading | ___ Lazy Eye | ___ Retinal Detachment |
| ___ Spots/Floaters | ___ Headaches | ___ Macular Degeneration |
| | | ___ Cataracts |

What do you like **LEAST** about your eyeglasses? _____

Do you have a **back-up pair** of glasses? YES NO

Will you be **purchasing** eyeglasses today? YES NO NOT SURE

Contact Lenses

1)How often do you wear contacts? Never Everyday 2-4x a month 2-4x a year

2)How many nights do you sleep in your contacts? _____ How often do you throw them away? _____

3)What is the name brand of your contacts? _____ What is the prescription? R _____ L _____

4)What do you like **LEAST** about your contacts? _____

Occupation/ Social History:

1)Occupation (or Grade in school) _____

2) how many **hours per day**: driving ___ outdoors ___ using computers ___

3) In what type of activities do you participate on a weekly basis? Water sports, fishing, boating, walking/running, gym, Basketball, football, soccer, baseball, or other _____

4) How often do you **smoke**, or use **tobacco**? Never <1pk/day 1or 2pks/day >2pks a day
How often do you drink **alcohol**? Never Social Use 1-2 drinks daily >2drinks daily

Do you use **illegal drugs**? YES NO

Have you ever been exposed or infected with:Gonorrhea Hepatitis HIV Syphillis None

Family History

Which family members(Mom, Dad, Sister, Brother, Maternal Grandmother, Maternal Grandfather, Paternal Grandmother, Paternal Grandfather, or NONE) have the following diseases?

Systemic Health:

Diabetes? _____

Cancer? _____

Heart disease? _____

Ocular Health:

Glaucoma? _____

Macular Degeneration? _____

Crossed Eyes, Retinal Detachment? _____

Authorization

I request that payment of authorized Insurance Benefits be made on my behalf to Dr. Cristina Sicoia for any services furnished me, or my dependents. I authorize any holder of medical information about me, to release to the health care financing administration and its agents, any information need to determine these benefits or the benefits payable for related services. I acknowledge that I have read/reviewed a copy NOTICE OF PRIVACY PRACTICE (HIPAA). It can be found on website: www.visioncarefamily.com

Patient Signature _____ Today's Date _____

IF Minor, Guardian Signature _____ Today's Date _____

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Dilated Examination Refusal and Release of Liability

- Dilation of the pupils is an essential component of every comprehensive eye examination. Should you refuse dilation the doctor is not able to see 60-70% of the structures of your eye. There is no fee for this test. It is routinely done with your eye exam.
- Dilation allows Dr. Sicoia to detect eye diseases easier, such as: glaucoma, macular degeneration, cataracts and retinal tears/holes and others. Systemic illnesses, such as: high blood pressure and diabetes can also be detected during a thorough dilated eye exam.
- “I understand by declining dilation I hereby remise, release, acquit, satisfy and discharge Dr. Cristina Sicoia of and from all action or actions, cause and causes of action, suits, debts, damages, judgments, claims and demands, whatsoever, which said releasor ever had, now has, hereafter can, shall or may have against Dr. Sicoia. I sign this release voluntarily with knowledge of its significance intending to be legally bound thereby.”

X _____ X _____ X _____
Signature of Patient/or Guardian Print Name of Patient Date

Visual Field Screening

- DR SICOIA now incorporates an additional test to her routine eye care, on a yearly basis. It is a computerized **screening** (3-5 minutes) testing your side vision. **Copay for this test is \$15.00**
- The Visual Field **Screening** can detect diseases such as pituitary tumors, compression along the optic nerve (within the brain) or any history of parital strokes, advanced glaucoma, retinal and macular degeneration, retinal disturbances due to vascular problems or medications.
- Please speak to the pretesting Doctor or staff member if you have any concerns about doing this test.

X _____ X _____ X _____
Signature of Patient/or Guardian Print Name of Patient Date