SUMMIT
VISION SOURCE

Patient Information

Name: _____ Date of Birth: _____ Gender: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Phone (Cell/Home/Work): _____

Email Address: _____ Social Security Number: _____

Employer: _____ Occupation: _____

Medical Insurance Provider: _____ Member ID: _____

Vision Insurance Provider: _____ Member ID: _____

Secondary Insurance: _____ Member ID: _____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Phone Number: _____

Date of last eye exam: _____ Reason for visit today: _____

What are your visual symptoms? (Circle all that apply)

Blurry Distance Vision	Burning Eyes	Floaters or Spots	Headaches
Blurry Near Vision	Itchy Eyes	Seeing Flashes	Migrain Headaches
Double Vision	Eye Injury	Dry Eyes	Poor Night Vision
Crossed/Turned Eyes	Eye Strain	Red Eyes	Light Sensitivity
Eye Infection	Watery Eyes	Lid Pain	Sandy/Gritty Feeling

Do you wear glasses? _____ If yes, when do you wear them? All the time Reading Working Driving

Do you wear contact lenses? _____ If yes, what type/brand: _____

Personal Medical Information

Do you have any eye conditions or problems? _____ If yes, what kind: _____

Have you had any eye operations? _____ If yes, what type and date: _____

Have you had an eye injury? _____ If yes, what type and date: _____

List all current medications (or provide list): _____

Any allergies? _____ If yes, please list: _____

Are you pregnant? _____ Are you nursing? _____ Are you trying to get pregnant? _____

Do you smoke? _____ Do you drink alcohol? _____ Do you use recreational drugs? _____

Have you or a family member been diagnosed with any of the following: (Please write who was diagnosed)

Glaucoma _____ Cataracts _____ Eye Surgery _____

Diabetes _____ Macular Degeneration _____ Retinal Detachment _____

Heart Disease _____ High Blood Pressure _____ Crossed/Lazy Eye _____

Arthritis _____ Multiple Sclerosis _____ Asthma _____

Cancer _____ Other Eye Disease _____ Other _____

I give permission for the following person(s)at access my account and medical records:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

We respect HIPAA to keep your health information private.

_____ _____

Patients Signature or Patient's Legal Representative Date