Jill M. Barker O.D. Cadiz Vision Center

Name _____ Date of Birth _____/_____/_____
First MI Last

Circle: Male Female SSN: _____

Address _____
Street City State Zip code

Home Phone: _____ Cell Phone: _____

Employer: _____ Work Phone: _____

Occupation: _____ Preferred Contact: Home Cell Work

Parent's Name (IF MINOR) OR Medical POA: _____
HIPPA Appointed Person(s): _____
Person we can discuss your medical records with

Insurance Comp #1 _____ Subscriber _____

Insurance Comp #2 _____ Subscriber _____
We need copies of all insurance cards – BOTH medical and vision.

EYE HEALTH – Check ALL that apply

____	Amblyopia (Lazy Eye)	____	Eye Surgeries	____	Headaches
____	Blurred Vision – FAR	____	Eye Turn	____	Itchy Eyes
____	Blurred Vision – NEAR	____	Flashes of Light	____	Loss of Vision
____	Burning Eyes	____	Floaters/Spots	____	Macular Degeneration
____	Cataracts	____	Foreign Body Sensation	____	Redness of Eyes
____	Double/Distorted Vision	____	Glaucoma	____	Retinal Detachment/Tear
____	Dry Eyes	____	Glare/Light Sensitivity	____	Tearing/Watery Eyes

I wear glasses: YES _____ NO _____ Laser Vision Correction: YES _____ NO _____

I wear contacts: YES _____ NO _____ Type: _____ Replace Every: _____

Date of Last Eye Exam: _____/_____/_____ Previous Eye Doctor: _____

FAMILY HEALTH HISTORY – PLEASE CHECK ALL THAT APPLY

		RELATIONSHIP			RELATIONSHIP
____	Glaucoma	_____	____	Diabetes	_____
____	Blindness	_____	____	Hypertension	_____
____	Cataracts	_____	____	High Cholesterol	_____
____	Macular Degeneration	_____	____	Thyroid	_____
____	Retinal Detachment	_____	____	Cardiovascular	_____
____	Crossed/Lazy	_____			

PLEASE COMPLETE OTHER SIDE

Primary Care Doctor: _____ Phone Number: _____

Endocrinologist: _____ Phone Number: _____

Specialist: _____ Phone Number: _____

List ALL Medications: _____

_____

Do you have any allergies (MEDICAL OR GENERAL)? YES NO (IF YES, PLEASE LIST.)

_____

GENERAL HEALTH INFORMATION – PLEASE CHECK ALL THAT APPLY

____ Arthritis/Joint
____ Asthma
____ Blood Disorder _____
____ Cancer – Type _____
____ Constitution (Fever/Weight Change)
____ Diabetes – Date of Diagnosis _____
____ Ear/Nose/Throat/Mouth _____
____ Heart Condition/Disease _____
____ High Blood Pressure (even if controlled)
____ High Cholesterol (even if controlled)
____ Immune Deficiency _____
____ Kidney or Liver _____
____ Lung/Respiratory _____
____ Neurological (MS, Seizures)_____
____ Pregnant – EDD _____
____ Psychological – Depression Anxiety
____ Skin Condition _____
____ Stomach/Gastrointestinal _____
____ Stroke/TIA – Date(s) _____
____ Thyroid - Hyper/Over Hypo/Under

Tobacco Use: Light Moderate Heavy None Smokeless
Alcohol Use: Light Moderate Heavy None
Recreational Drug Use: Light Moderate Heavy None
Please list any other medical conditions: _____

_____

PLEASE READ AND SIGN.

By signing this release, I authorize the Cadiz Vision Center to bill my insurance for appropriate coverage and authorize payment to be made to Jill M Barker OD/Cadiz Vision Center LTD. Please be advised, your insurance may not cover all services and/or materials. Authorization does not constitute payment and I understand that I am ultimately responsible for this account, including incurred legal fees and to redeem fees if necessary.

I also consent to the release of my past medical/optical records if they are deemed necessary for my eyecare needs. I consent for the Cadiz Vision Center to release my medical records for the purpose of Health Care Operations. I understand that I may revoke this consent by written request, at any time, with this doctor and practice. If revoked, it is understood that by all parties that all information released prior to being notified of such revocation was made with my consent.

I have been provided/offered a copy of the Privacy Policy. (You may request a copy for your records.)

Signature _____ Date ____/____/_____

Relationship to Patient _____

PLEASE COMPLETE OTHER SIDE