VISION SOURCE TULSA

MEMBER VISION SOURCE® NETWORK

Terry Lawson, O.D. | Kelsy Simpson, O.D. | Abbas Malik, O.D.

Last Name_____ First Name_____ MI___

Sex: M F DOB___/___/_____ SSN: _____-_____-_____

Street Address_____
City_____ State_____ Zip_____
Phone: (Home) _____ (Cell/Other) _____
Email: _____
Occupation_____ Employer (or school)_____

Emergency Contact: _____
Phone Number: _____

Insurance Information

Primary Medical Insurance _____
Subscriber Name _____
Subscriber ID _____
Group Number _____
Subscriber Birth Date ____/____/_____

How did you hear about us? _____

Medical History Questionnaire

Patient Eye History

Do you experience any of the following

☐ Blurry Vision ☐ Tearing ☐ Floaters

☐ Dryness ☐ Discharge ☐ Light Flashes

☐ Burning ☐ Eye Turn ☐ Headaches

☐ Itching ☐ Double Vision

Date of Last Eye Exam ____/_____/_____

Are you planning to get new glasses today? ☐ Y ☐ N

Do you currently wear contact lenses? ☐ Y ☐ N
What Kind? _____
Are you satisfied with your current contacts? ☐ Y ☐ N

Have you been diagnosed/treated for the following:

☐ Cataracts ☐ Glaucoma ☐ Eye Infection

☐ Iritis/Uveitis ☐ Lazy Eye ☐ Eye Trauma

☐ Retinal Detachment ☐ Macular Degeneration

Other_____

Family Medical/Eye History (Check all that apply)

Relationship

Blindness _____
Glaucoma _____
Lazy Eye _____
Macular Degeneration _____
Retinal Detachment _____

Patient Medical History

Have you been diagnosed/treated for the following:

☐ Allergies ☐ Asthma ☐ Arthritis

☐ Cancer ☐ Diabetes ☐ Cholesterol

☐ Heart Disease ☐ High Blood Pressure

Other _____

If female, are you Pregnant or Nursing? ☐ Y ☐ N

Date of last medical exam ____/_____/_____

Height:_____ Weight:_____

Current Medication (prescription or over the counter)
_____
_____
_____

Allergies to Medications? ☐ Y ☐ N
If yes, please explain: _____
_____

Privacy Agreement*:

I consent to the use and disclosure of my health information for purposes of treatment, payment, and health care operations. I understand that if my insurance does not cover the charges for services and/or materials, I am responsible for the amount due.

Signature _____

_____
(Relationship to patient if patient under 18) Date

***Notice of Privacy Practices can be furnished upon request**