



NAPER GROVE VISION CARE

29 S. Webster St. Suite 200
Naperville, IL 60540

5018 Fairview Avenue
Downers Grove, IL 60515

PATIENT INFORMATION

The information contained herein is a part of your medical record and will be kept confidential. No information will be released without the consent of the patient or the patient's guardian.

Date ____/____/____

PATIENT: Mr. ____ Mrs. ____ Ms. ____ Miss. ____ Dr. ____

Last Name: _____ **First Name:** _____ **Middle Int.:** _____

Nickname: _____ **Marital Status:** Married Single Divorced Widowed

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home #: _____ **Work #:** _____

Employer: _____ **Occupation:** _____

Sex: M ____ F ____ **Social Security #:** _____ **Birthdate:** _____

Email Address: _____ **Primary Care Doctor & Phone:** _____

GUARANTOR (Person Responsible for Payment): Mr. ____ Mrs. ____ Ms. ____ Miss. ____ Dr. ____

Last Name: _____ **First Name:** _____ **Middle Int.:** _____

Address (if different): _____

City: _____ **State:** _____ **Zip:** _____

Home #: _____ **Work #:** _____

Employer: _____ **Occupation:** _____

Sex: M ____ F ____ **Social Security #:** _____ **Birthdate:** _____

INSURANCE: (Circle One) **Members Name:** _____ **INS. ID#:** _____

Members DOB: _____ **Group #:** _____

Vision Service Plan (VSP) Vision Max Cigna BCBS Medicare

Spouse's Name (if applicable): _____

Children's Name/Age (if dependents): _____

How did you hear about our office?

Referred by: _____ Residential Greeter Program Other: _____

Insurance Company: _____ Yellow Pages Internet

(Please turn over to complete side 2)

Medical History

Date: _____

Do you have any allergies to medications? no yes If yes, explain: _____

Do you have any environmental/food allergies? no yes If yes, explain: _____

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies):

List all major injuries, surgeries and/or hospitalizations you have had: _____

Are you pregnant and/or nursing? no yes

Do you wear glasses? no yes

Do you wear contact lenses? no yes Type: _____

Hobbies and sports: _____

Self/Family History

Please note any self or family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

<u>DISEASE/CONDITION</u>	<u>N/A</u>	<u>SELF</u>	<u>FAMILY</u>	<u>RELATIONSHIP TO YOU</u>
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

If you answered YES to any of the above or have a condition not listed, please explain & list medications:

Social History Please fill out if you are over 14 years old.

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

Yes, I would prefer to discuss my Social History information directly with my doctor. (Check box)

Do you use Cigarettes, Tobacco, Alcohol or any Other substance(s)? no yes If yes, type/amount/how long: _____

Patient's Signature

Date

Doctor's Signature

Date