Foley Vision Center

Patient Name:______________________ DOB:_________
Email Address:_____________________ Can we contact you by email: Y N

Please CIRCLE all condition that apply to YOU:

Diabetes	**High Blood Pressure**	**Heart Disease**	**Cancer**
High Cholesterol	**Thyroid Disease**	**Asthma**	
Neurological Disease	**Headaches**	**Head Trauma**	**Cataracts**
Glaucoma	**Macular Degeneration**	**Lazy Eye**	**Eye Injury**
Eye Surgery	**Double Vision**	**Floaters/Spots**	**Dry Eyes**

Other:_____________________

Do you wear CONTACT LENSES? Y N If Yes: Which brand?____________
If No: Are you interested in Contact Lenses? Y N

Please CIRCLE all conditions that apply to your BLOOD RELATIVES:

Diabetes	**High Blood Pressure**	**Macular Degeneration**
Cataracts	**Glaucoma**	**Blindness**

Other:_____________________
Do you (CIRCLE if yes): Smoke Drink Alcohol

Females: Are you (CIRCLE if yes): Pregnant or Nursing

List Medications:____
Allergies:____

I acknowledge that I have received a "Notice of Privacy Practices" from Foley Vision Center. I authorize the direct payment of medical and/or vision benefits to Foley Vision Center for services rendered and/or materials supplied. I accept financial responsibility for any unpaid balances not covered by my medical/vision insurance for services for rendered or materials supplied to me, my spouse or my dependents. I authorize the release of any information necessary to process this claim. I authorize Foley Vision Center to store an electronic copy of the medical file as long as required by law. I authorize Foley Vision Center to verify my current medications and/or submit prescriptions to my pharmacy electronically.

Patient or Guardian Signature:_____________________ Date:____________