



Brandy E. Hicks, OD

Phone: (828) 586-8080 • Fax: (828) 586-8066
400 East Main St. • P.O. Box 2218 • Sylva, NC 28779

WELCOME TO OUR OFFICE

LAST FIRST MIDDLE

Date of Birth: _____ Age: _____ Sex: Male/Female

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: () _____ Business Phone: () _____

Social Security Number: _____

Place of Employment: _____ Occupation: _____

If child, name of parents: _____

Parents' Employer: _____ Business Phone: () _____

If married, name of Spouse: _____

Spouse's Employer: _____ Business Phone: () _____

Reason for today's visit: _____

How were you referred to our office? _____

INSURANCE

Please give all insurance cards to receptionist upon arrival.

Policy Holder: _____ Date of Birth: _____

Social Security: _____ Employer: _____

PLEASE NOTE:

It is the patient's responsibility to know if they are covered by their insurance plan for "Routine Vision." Contact Lens Fittings are usually NOT covered by insurance. Be prepared to pay any additional cost for this service. The patient is responsible for all fees, regardless of insurance.

I request that payment of authorized insurance benefits be made directly to Mountain View Eye Care and its affiliated doctors for any services provided to me. I authorize any holder of medical information about me be released to the health care financing administration and its agents as well as any information to determine these benefits or benefits payable for related services.

PATIENT SIGNATURE: _____ DATE: _____

**MOUNTAIN VIEW EYE CARE
Patient Health History**

NAME: _____

DATE: ____/____/____

DATE OF LAST EYE EXAM: ____/____/____

PRIMARY CARE PHYSICIAN: _____

MEDICAL HISTORY

HAVE YOU OR A BLOOD RELATIVE EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING?

NO	YES	FAMILY		NO	YES	FAMILY	
			Arthritis/Musculoskeletal Problems				Psychiatric Disorder
			Asthma or Breathing Problems				Seizures, Convulsions, Fainting
			Cancer				Skin Disease
			Carotid Artery Disease				Stroke/other Neurological Diseases
			Diabetes				Temporal Arteritis
			Gastrointestinal Disease/Ulcers				Thyroid Trouble
			Heart Disease				Other:
			High Blood Pressure				Do you smoke?
			HIV Infection or AIDS				If yes, how many packs per day?
			Kidney Disease				Do you drink alcohol?
							If yes, how many drinks per day?

OCULAR HISTORY

HAVE YOU OR A BLOOD RELATIVE EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING?

NO	YES	FAMILY		NO	YES	FAMILY	
			Cataracts				Macular Degeneration
			Cornea Disease				Retinal Disease
			Crossed Eyes/Lazy Eye				Other Eye Disorders
			Glaucoma				If yes, please explain.
			Iritis				

DO YOU HAVE ANY OF THE FOLLOWING?

NO	YES		NO	YES	
		Blurred Vision			Foreign Body Sensation/Gritty Feeling
		Burning			Eye Pain/Soreness
		Itching			Floaters/Flashing Lights
		Redness			Headaches
		Dryness			Loss of Side Vision
		Excess Tearing/Watering			History of Eye Surgery? When?
		Discharge			History of Eye Injury? When?

List any Medications that you are currently taking (Prescription and Non-Prescription): _____

List any Allergies to Medication: _____

List all Surgeries, Major Injuries or Hospitalizations: _____

Are you Pregnant or Nursing?: _____

Do you Drive? _____ If yes, do you have any Visual Difficulty when Driving? _____

Do you wear Contact Lenses? _____ If yes, please list the Brand and Prescription: _____
 If no, are you interested in Contact Lenses? _____

Doctor's Signature: _____

Review Date: _____