Coopersville Visi ɔn Center

Aimee Bronson, O.D.

Patient Information:

Name (First, Middle, Last): _____ Date: _____ ☐ Single ☐ Married

Address: _____ City: _____ St:____ Zip: _____ ☐ Widowed

Home Phone: _____ Cell Phone: _____ Email: _____

Gender: ☐ Male ☐ Female Birthdate: _____ Occupation: _____ Employer: _____

Emergency Contact: _____ Relationship: _____ Phone Number: _____

Whom may we thank for referring you? _____

Vision Insurance: _____ Policy Holder: _____ Relationship: _____ DOB: _____

Health Insurance: _____ Policy Holder: _____ Relationship: _____ DOB: _____

Policy Holder's SSN/Insurance #: _____

Eye Health History:

Date of Last Exam: _____

Do you wear glasses? ☐ yes ☐ no

Do you wear contact lenses? ☐ yes ☐ no

If Yes, what Brand: _____

How often do you replace them? _____

Have you had the following?:

☐ Cataracts

☐ Macular Degeneration

☐ Crossed or Lazy Eye

☐ Glaucoma

☐ Eye Surgery or Injuries-Please Describe:

_____

_____

Please list ALL medications you take:

_____

_____

_____

_____

Are you allergic to ANY medications? N___ Y____

Which ones? _____

Primary Care Doctor: _____

List all surgeries: _____

_____

_____

Do you use tobacco? N_____ Y_____

Alcohol? N___ Y___Other substances? N___ Y___

Height: _____ Weight: _____ Race: _____

Do you have any health problems? Please check Yes/No for every line

Cardiovascular (i.e., Heart, Blood Pressure, Cholesterol)	No____	Yes (explain)_____
Respiratory (i.e., Breathing, Asthma, COPD, Lungs)	No____	Yes (explain)_____
Mental (i.e., Depression, ADD, Mental Disorders)	No____	Yes (explain)_____
Gastrointestinal (i.e., Reflux, Food Intolerance, Stomach Problems)	No____	Yes (explain)_____
Allergic/Immunologic (i.e., Allergies, Immune System Disorders)	No____	Yes (explain)_____
Musculoskeletal (i.e., Arthritis, Muscle, Joint, Bone Problems)	No____	Yes (explain)_____
Endocrine (i.e., Diabetes, Thyroid, Glands)	No____	Yes (explain)_____
Ear/Nose/Throat (i.e., Tubes, Miner's, Vertigo, etc.)	No____	Yes (explain)_____
Nervous (i.e., Dementia, Alzheimer's, Carpel Tunnel, Nerve Problems)	No____	Yes (explain)_____
Integumentary (Skin Problems. i.e., Cancer)	No____	Yes (explain)_____
Blood/Lymph (i.e., Hepatitis, Clotting Disorders)	No____	Yes (explain)_____

Other _____

Does anyone in your family have the following:

	Relationship
High Blood Pressure	N___Y_____
Diabetes	N___Y_____
Glaucoma	N___Y_____
Macular Degeneration	N___Y_____
Retinal Detachment	N___Y_____
Other_____	

I have accurately answered the above questions to the best of my knowledge. I authorize Coopersville Vision Center to use or release any information, including the diagnosis and the records of any treatment or examination given to me or my child, to third party payers and/or health practitioners. I understand that I will be responsible for charges not covered by the Insurance Company. I do authorize payment to be made directly to Coopersville Vision Center.

_____ Date:_____

Signature of Patient/or Parent/Legal Guardian of a Minor

☐ Patient Reviewed _____ Date:_____

☐ Patient Reviewed _____ Date: _____

☐ Patient Reviewed _____ Date: _____

☐ Patient Reviewed _____ Date: _____

Coopersville Vision Center
692 W. Randall Rd.
Coopersville, MI 49404
616-837-6847

Privacy Practices Patient Acknowledgement Form

I have received the Notice of Privacy at Coopersville Vision Center.

This notice provides an understanding of the uses and disclosure of my Protected Health Information, in plain language.

I understand that his practice reserves the right to change those terms of it's Notice of Privacy Practices and will provide me with a revised Notice of Privacy Practices upon request.

PATIENT NAME:_____ **BIRTH DATE:** _____

SIGNATURE:_____ **DATE:**_____
(IF UNDER 18, SIGNATURE OF PARENT OR GUARDIAN)

The following person(s) are authorized to receive my personal medical information. The following person(s) listed will also be able to pick up any supplies, eyeglasses, contacts, or other items deemed necessary.

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____

SIGNATURE:_____ **DATE:**_____
(IF UNDER 18, SIGNATURE OF PARENT OR GUARDIAN)