PORTAGE VISION CARE
MEDICAL HISTORY

Date _____ ❑ New Patient ❑ Previous Patient

Patient Name _____ Birth Date _____ Age _____ M or F *(circle)*
Please Print

Address _____ City _____ State _____ ZIP _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email _____ Employer _____ Occupation _____

Emergency Contact/Phone # _____ Social Security # _____

Date of Last Eye Exam _____ Name of Previous Eye Doctor _____

Name of Medical Insurance _____ Name of Policy Holder _____

ID # _____

Name of Vision Insurance _____

MEDICAL INFORMATION: DO YOU HAVE PROBLEMS WITH ANY OF THESE SYSTEMS?
If Yes, Please Check Box.

- ❑ Gastrointestinal
- ❑ Ear/Nose/Throat
- ❑ Cardiovascular
- ❑ Respiratory (COPD)
- ❑ Headaches
- ❑ Nervous System
- ❑ Genitourinary
- ❑ Musculoskeletal (Arthritis)
- ❑ Skin
- ❑ Surgeries (what type & when)
  _____
  _____
- ❑ Blood/Lymph
- ❑ Allergic/Immunologic
- ❑ Mental
- ❑ Endocrine (Glands)

Allergies ❑ Yes ❑ No *If Yes, please list* _____

Name of General Physician _____

Please check Yes or No

Do you smoke? ❑ Yes ❑ No How much? _____

Do you drink alcohol? ❑ Yes ❑ No How much? _____

Do you take medications? ❑ Yes ❑ No Please list names and how often _____

_____

Do you or any family member have any of the following? If Yes, check box and identify family member relationship.

❑ Glaucoma ❑ Macular Degeneration ❑ Retinal Detachment ❑ Amblyopia/Lazy Eye ❑ Diabetes ❑ High Blood Pressure

Please explain any boxes you checked _____

_____

Do you have any of the following? If Yes, please check box.

❑ Flashing Lights/Floaters ❑ Dry Eyes ❑ Double Vision ❑ Wear Contact Lenses ❑ I am interested in contact lenses.

❑ Eye Surgeries/Injuries – Please explain. _____

Any eye problems at this time? Please explain. _____

INSURANCE AGREEMENT AND HIPAA PRIVACY

Please note that your insurance may cover none or only part of your fees. If your insurance company does not pay as expected, you agree to be responsible for all charges. We can not be responsible if you are not eligible for benefits. Any unpaid balances will be turned over to a collection agency after 90 days. **(Please initial)** _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have been presented with the Notice of Privacy Policy of Dr. Gregory A. Marchand and Associates, Inc. and have been offered a copy of such policy to keep for my records.

Patient/Parent Sign _____ **Date** _____