WELCOME TO VISIONCARE FAMILY!

Address: 5540 S Flamingo Rd. Cooper City, FL. Phone 954-434-2020
Please FAX: 954-434-2104 or BRING this form to your appointment!

☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr
Last Name: _____ First Name: _____ Birthdate: _____
Address: _____ City: _____ State: ____ Zip: _____
Home Phone: _____ Work: _____ Cell: _____
Employer or School: _____SSN: _____
MEDICAL Insurance Name: _____ ID: _____
Main Member (if different) Name:_____ SSN: _____ DOB: _____
E-mail address: (email addresses are for our office use only)

Recommended by? ☐ By my Doctor/Insurance: _____ ☐ By Friend/Family: _____

Medical Health

Medications	Dosage	Condition	Year (started)

Write any **DRUG ALLERGIES**: _____
List ALL **Surgeries** and **YEAR**: _____
_____
_____

Are you currently pregnant or nursing? ☐ YES ☐ NO

Medical History
Last Medical Exam: _____ Name of Physician: _____
Physician's Phone: _____ Fax: _____

Please Circle history of your systemic diseases: present or past

Vascular: ☐Chest pain ☐High blood pressure ☐Cholesterol ☐Heart dz ☐Stroke ☐Arrythmia ☐Murmur
Constitutional: ☐Weight gain ☐Weight loss ☐Nausea ☐Constipation ☐Vomit ☐Diarrhea ☐Fatigue Fainting
Endocrine: ☐Diabetes ☐Diabetes Suspect ☐Thyroid dz ☐Gout ☐Crohn's ☐Pituitary dz
Gastrointestinal: ☐Acid Reflux ☐Gallbladder ☐ Ulcer ☐Stomach/Colon cancer ☐Cirrhosis ☐Liver dz
Genitourinary: ☐Menopause ☐Kidney stones ☐Bladder infections ☐Impotence ☐Ovarian cysts ☐Prostate dz
Ear/Nose/Throat: ☐Post Nasal Drip ☐Hearing Loss ☐Dry Mouth ☐Ear Infections
Hematological/ Lymphatic: ☐Anemia ☐Bleeding dz ☐Hodgkin's ☐Sickle Cell ☐Varicose ☐Breast Cancer
Immunological: ☐HIV ☐Aids ☐Herpes simplex ☐Herpes zoster ☐Sjogren's ☐Lyme dz ☐Mononucleosis
Skin: ☐Acne ☐Psoriasis ☐Dermatitis ☐Hair Loss ☐Acne Rosacea ☐Urticaria ☐Impetigo ☐Lupus
Musculoskeletal: ☐Arthritis ☐Osteoporosis ☐Joint Pain ☐Scoliosis ☐Paget's ☐Ankylosis Spondilitis ☐Down's
Neurological: ☐Headache ☐Seizure ☐Parkinson ☐MS ☐Nystagmus ☐Vertigo ☐Bell's Palsy ☐Epilepsy ☐Dyslexia
Psychiatric: ☐Depression ☐Anxiety ☐ADD ☐Bipolar ☐Insomnia ☐Alzheimer's ☐Autism ☐Mentally Challenged
Respiratory: ☐Asthma ☐Bronchitis ☐COPD ☐Emphysema ☐Lung cancer ☐Sarcoidosis ☐TB ☐Pneumonia
Other: _____

Eye Health/Eyeglasses

Date of last EYE exam _____ Name of last EYE doctor _____

Any of the following eye problems?

☐ Blurred vision	☐ Red/Gritty/Dry	☐ Eye Surgery: Lasik, RK, Cataract
☐ Eyestrain when reading	☐ Blinking/Tearing	☐ Retinal Detachment
☐ Spots/Floaters	☐ Headaches	☐ Macular Degeneration

What is your goal for today's visit? _____

What bothers you when wearing eyeglasses?_____

Contact Lenses

How often do you wear contacts? ☐ Never ☐ Everyday ☐ 2-4x a month ☐ 2-4x a year

How many nights do you sleep in your contacts? _____ How often do you throw them away? _____

Name brand of your contacts?_____ What prescription? R _____ L _____

What bothers you when wearing contacts?_____

Occupation/ Social History

Occupation: _____ Hobbies: _____

How many **hours per day**: Driving _____ Outdoors_____ Using Computers_____

How often do you **Smoke**, or use **Tobacco**?	☐ Never	☐Former	☐ Everyday	☐ Tobacco smoker
Former Smoker: When did you **quit**?	☐ < 1yr ago	☐ 1-4yr ago	☐ <5+yrs ago	☐ 10+yrs ago
How often do you drink **alcohol**?	☐ None	☐ Social Use	☐ 1-2 drinks/day	☐ >2drinks /day
Do you have any **Sexually Transmitted Disease**:	☐ None	☐ Yes	☐ HIV	

Family History

Write in which Family Members *(Mom, Dad, Sister, Brother, Maternal Grandmother, Maternal Grandfather, Paternal Grandmother, Paternal Grandfather, or NONE)* have or had the following diseases:

Systemic Health	Ocular Health
Diabetes:	Glaucoma:
Cancer:	Macular Degeneration:
Heart Disease:	Crossed Eyes/Retinal Detachment

Authorizations

1) I request that payment of authorized Insurance Benefits be made on my behalf to Cristina Sicoia, OD for any services furnished me, or my dependents. I authorize any holder of medical information about me, to release to the health care financing administration and its agents, any information needed to determine the benefits payable for related services.

2) Changes to HIPPAA Notice: We reserve the right to change our privacy practices and to apply the revised practices to health information about you that we already have. A revised Notice will be available to view in our facility. Copies of this Notice are also available upon request. Notice Revised and Effective: August 30, 2013.

3) Acknowledgement Receipt: I acknowledge that I reviewed a copy of Cristina Sicoia O.D., Notice of Privacy Practices.

4) Confidential Communication Request: I request that Visioncare Family may also communicate my protected healthcare information to my spouse or designated family member_____.
This request for confidential communications will apply to all future dates unless I request a change in writing.

5) Can we leave a voicemail on your cellphone or home phone? YES ____ NO_____
Can we use your email for communication? YES_____ NO_____

6) SATURDAY appointments. Cancellation Fees apply if 24hr cancellation notice is not given to this office.

7) Consent to treat MINOR CHILD: I am giving consent to Cristina Sicoia, OD to provide, solicit, or arrange health care services or prescribe medicinal drugs to the minor child.

Name of minor child: _____ Child birthdate: _____/_____/_____

Today's Date: ____/_____/_____ Patient or Guardian Name (Print) _____

Patient or Guardian Signature (Sign): _____

**** Please return this form to receptionist (with Insurance Cards and ID's)****