Welcome to Viking Vision Center

Drs. Michael & Julie Heidish

Please fill out this form completely.

Date: _____/_____/_____Reason for Visit: Glasses / Contact Lenses / eye pain / red eye / Other_____

Last Name: _____First Name: _____ I prefer to be called: _____

Address: _____ City: _____ State: _____ Zip: _____

Social Security #: _____Date of Birth: _____ **Primary Vision Insurance:** _____

Home Phone: _____ Cell Phone: _____ Communication Preference: Home phone / Cell Phone

Occupation: _____ Employer: _____

Emergency Contact: _____Phone #: _____ Last Eye Exam: _____

Insurance Information

Insureds Name: _____ Insureds Date of Birth_____

Insureds Social Security Number: Relation to patient:

Personal Medical History

N Y Allergic / Immune (Seasonal, HIV, Aids) Other: _____ Meds: _____

N Y Blood / Lymph (bleeding disorder, lymphoma) Other: _____Meds: _____

N Y Cardiovascular (high blood pressure, cholesterol) Other: _____ Meds: _____

N Y Ear / Nose / Throat (Sinus) Other: _____ Meds: _____

N Y Endocrine (diabetes, thyroid disorder) Other: _____ Meds: _____

N Y Eyes (lazy eye, retinopathy, LASIK) Other: _____ Meds: _____

N Y Gastrointestinal (acid reflux, ulcers) Other: _____ Meds: _____

N Y Genital / Urinary (bladder cancer, prostate cancer) Other: _____ Meds: _____

N Y Mental (anxiety, depression, ADD, ADHD) Other: _____ Meds: _____

N Y Nervous (headaches, fibromyalgia) Other: _____ Meds: _____

N Y Respiratory (asthma, lung disease) Other: _____ Meds: _____

N Y Skin (acne, psoriasis) Other: _____ Meds: _____

List known allergies: _____ Do you wear contacts? N Y Type: _____

Are you interested in contacts? N Y Have you had any eye operations? N Y _____ Do you smoke? N Y

Family History Information

Cataracts N Y Lazy/ Crossed Eye N Y Heart Disease N Y Diabetes N Y

Glaucoma N Y High Blood Pressure N Y Macular Degeneration N Y Other: _____

Insurance Acknowledgement / Privacy Acknowledgement

Please remember that most insurance companies do not cover your fees in full. You will be responsible for any deductibles, co-pays or non-covered items at the time of service. **RELEASE: I authorize Viking Vision Center to release any information required for insurance processing. I understand that I am responsible for all charges that my insurance company does not pay.**

Patient Signature (parent if minor): _____Date: _____

I acknowledge that I have been offered a copy of Viking Vision Center's Notice of Privacy Practices.

Patient Signature (parent if minor): _____Date: _____