# Patient Information

Name: _____ DOB: _____

Do you use a wheelchair? ◯ Yes ◯ No Are you hard of hearing? ◯ Yes ◯ No

Do you drive? ◯ Yes ◯ No If yes, do you have visual difficulty when driving? ◯ Yes ◯ No

If yes, please describe: _____

Do you use tobacco products? ◯ Yes ◯ No If yes, type / amount/ how long: _____

Do you drink alcohol? ◯ Yes ◯ No If yes, type / amount/ how long: _____

Do you use illegal drugs? ◯ Yes ◯ No If yes, type / amount/ how long: _____

Have you ever been exposed to or infected with: ◯ Hepatitis ◯ HIV ◯ Gonorrhea ◯ Syphilis

---

Family Physician: _____ Phone: _____

Pharmacy: _____ Phone: _____

| Medication: Prescribed / OTC (Including Vitamins) | Allergies: Medication / Food / Environmental | Surgery History |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

---

# Acknowledgement of Privacy Practices

Please list the family member(s) or other persons, if any whom we may inform about your medical information and diagnosis (including treatment, payment, and health care options):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I acknowledge that I have been given the right to review and receive a copy of Kilgore Vision Center's Notice of Privacy Practices. I understand that Kilgore Vision Center has the right to change this Notice, and I may obtain a current copy at any time.

_____ _____

Signature (patient or parent / guardian) Relationship

Print Form