Patient Information

First Name _____ Middle Initial___ Last Name_____ Date of Birth___/___/_____
Address_____ City_____ State____ Zip_____
Home Phone (_____) _____-_____ Cell Phone (_____) _____-_____ Email: _____

Insurance Information

Primary Vision Insurance_____ Vision Insurance ID_____
Secondary Vision Insurance_____ Secondary Vision Insurance ID_____
Medical Insurance _____ Medical Insurance ID _____
Primary Member's Name _____ Primary Member's Date of Birth _____/_____/_____
Please indicate the last four digits of the primary member's social security number _____
Primary Member's Employer _____

Health History

Height_____ Weight_____ Please list any allergies _____
Please list any medications _____

Please check any that apply:

Self	Family	
☐	☐	Cataracts
☐	☐	Diabetes
☐	☐	High Blood Pressure
☐	☐	Macular Degeneration
☐	☐	Heart Problems
☐	☐	Retinal Degeneration
☐	☐	Stroke
☐	☐	Thyroid Condition
☐	☐	Crossed Eyes or lazy eye
☐	☐	Glaucoma
☐	☐	Asthma
☐	☐	Color blindness
☐	☐	Arthritis
☐	☐	Tuberculosis
☐	☐	HIV
☐	☐	Hepatitis
☐	☐	Blindness
☐	☐	Neuromuscular Disease
☐	☐	Cancer
☐	☐	High Cholesterol

Please check any that apply:

- ☐ Poor night vision
- ☐ Eye strain
- ☐ Headaches
- ☐ Blurry distance vision
- ☐ Trouble reading
- ☐ Itchy Eyes
- ☐ Discharge
- ☐ Watering
- ☐ Eye pain
- ☐ Burning eyes
- ☐ Sandy/dry eyes
- ☐ Red eyes
- ☐ Frustration with blinding glare
- ☐ Sensitivity to bright lights
- ☐ Flashes of light
- ☐ Eye injury
- ☐ Double vision
- ☐ Spots or floaters in vision
- ☐ History of wearing an eye patch
- ☐ History of eye surgery

Please indicate how frequently you use:

Alcohol _____
Tobacco _____
Other recreational drugs_____

Would you like any of the following?

- ☐ New glasses
- ☐ Contact lenses
- ☐ Safety glasses
- ☐ Lasik
- ☐ Dry eye therapy
- ☐ Sunglasses

How did you hear about us?

- ☐ A friend or family member
- ☐ Insurance company
- ☐ Online search
- ☐ Location

Contact Lens Wearers

Renewing your contact lens prescription requires additional time, knowledge, and materials. Contact lens evaluations are a separate service from your routine eye exam. Most vision insurance plans do not cover contact lens evaluations because they are not considered medically necessary. If you would like to renew your contact lens prescription, or try contact lenses for the first time, please inquire at the front desk for additional information.

Privacy Practice/HIPPA Notice

This practice is concerned about the privacy of your patient's health care information. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your healthcare services will in no way be conditioned upon your signed acknowledgment. If you decline to provide a signed acknowledgment, we will continue to provide your treatment and will use and disclose your protected health information for treatment, payment and health care operations when necessary.

Agreement

I consent to the release of any medical information necessary to process my insurance claim and authorize payment from my healthcare insurance to Vision Plus. I understand that I am responsible for payment of any charges not covered fully by my insurance benefits and any insurance claim not paid by my insurance 90 days after submission of the claim. I understand that no refund can be made on clinical procedures or services provided including comprehensive eye exams, refractions, contact lens fittings and medical office visits. I understand that frame sales are final, and contact lens boxes may only be returned if they are unopened within 30 days of purchase.

Patient/Guardian Signature _____ **Date**_____/_____/_____