WELCOME TO OUR OFFICE!

PLEASE PRESENT ALL VISION AND MAJOR MEDICAL INFORMATION TO RECEPTIONIST

Please Print

Patient's Full Legal Name ______________________

Date ______________________

Address ______________________

Phone ______________________

______________ Zip Code __________

Work Phone ______________________

Birth Date ____/____/____ SS# ____/____/____

Last Eye Exam ____/____/____

Spouse ______________________

Prev. Eye Dr. ______________________

Birth Date ____/____/____ SS# ____/____/____

Last Medical Exam ______________________

If child, Parent or Guardian ______________________

Family Doctor ______________________

Student ❑ Yes ❑ No If yes, Grade ______________

Occupation ______________________

Employer ______________________

Your Hobbies ______________________

List other family members who are our patients ______________

____

Who recommended us? ______________________

Email Address ______________________

Eye Health History

Have YOU had any of the following?

- ❑ Cataracts
- ❑ Crossed Eye
- ❑ Droopy Eyelids
- ❑ Eye Injury
- ❑ Glaucoma
- ❑ Lazy Eye
- ❑ Macular Degeneration
- ❑ Protruding Eyes
- ❑ Refractive Surgery
- ❑ Retinal Disease

	No	Yes
Are you using any prescription or non-prescription eye drops?	❑	❑
List: ______________________		
Do you wear glasses? (If so, how old is your current pair? __________)	❑	❑
Do you wear contact lenses? (If so, how old is your current pair? ______)	❑	❑
Are they comfortable?	❑	❑

Type ❑ Rigid ❑ Soft ❑ Disposable ❑ Non-Disposable
❑ Sleep-In ❑ Toric ❑ Mono ❑ Bifocal

	No	Yes
Are you interested in contact lenses?	❑	❑
Are you interested in refractive surgery?	❑	❑

Family History

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

Disease/Condition	No	Yes	
Blindness	❑	❑	______________
Cataract	❑	❑	______________
Crossed Eyes	❑	❑	______________
Glaucoma	❑	❑	______________
Macular Degeneration	❑	❑	______________
Retinal Detachment/Disease	❑	❑	______________
Arthritis	❑	❑	______________
Cancer	❑	❑	______________
Diabetes	❑	❑	______________
Heart Disease	❑	❑	______________
High Blood Pressure	❑	❑	______________
Kidney Disease	❑	❑	______________
Lupus	❑	❑	______________
Thyroid Disease	❑	❑	______________
Other	❑	❑	______________

Please Complete Both Sides of the Form

OVER →

Social History

This information is strictly confidential, you may discuss this portion directly with the doctor if you prefer.

☐ Yes, I would prefer to discuss my Social History directly with the doctor.

Do you drive? ☐ Yes ☐ No If yes, do you have any vision difficulty when driving? Please describe:

____

Do you use tobacco? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No

Do you use recreational drugs? ☐ Yes ☐ No

Have you ever been exposed to or infected with? ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis

☐ Are you pregnant? ☐ Yes ☐ No Months:________

☐ Are you breastfeeding? ☐ Yes ☐ No

Review of Systems

Do you currently have, or have you ever had, any of the following problems or conditions?

	No	Yes
Constitutional		
Fever, Weight Loss/Gain	☐	☐
Integumentary (skin)		
Skin Cancer	☐	☐
Skin Disease	☐	☐
Neurological		
Headaches	☐	☐
Migraines	☐	☐
Multiple Sclerosis	☐	☐
Gout	☐	☐
Seizures	☐	☐
Eyes		
Loss of Vision	☐	☐
Blurred Vision	☐	☐
Distorted Vision/Halos	☐	☐
Loss of Side Vision	☐	☐
Double Vision	☐	☐
Dryness	☐	☐
Mucous Discharge	☐	☐
Redness	☐	☐
Sandy/Gritty Feeling	☐	☐
Itching	☐	☐
Burning	☐	☐
Foreign Body Sensation	☐	☐
Excess Tearing/Watering	☐	☐
Glare/Light Sensitivity	☐	☐
Eye Pain/Soreness	☐	☐
Chronic Infection	☐	☐
Sty/Chalazion	☐	☐
Flashes/Floaters	☐	☐
Tired Eyes/Eyestrain	☐	☐
Endocrine		
Thyroid/Other Glands	☐	☐
Immunologic (Cancer)	☐	☐

	No	Yes
Ears/Nose/Mouth/Throat		
Allergies	☐	☐
Sinus Congestion	☐	☐
Post Nasal Drip	☐	☐
Chronic Cough	☐	☐
Dry Mouth/Throat	☐	☐
Respiratory		
Asthma	☐	☐
Chronic Bronchitis	☐	☐
Emphysema	☐	☐
Vascular / Cardiovascular		
Diabetes	☐	☐
Heart Disease	☐	☐
High Blood Pressure	☐	☐
High Cholesterol	☐	☐
Stroke	☐	☐
Vascular Disease	☐	☐
Gastrointestinal		
Constipation	☐	☐
Crohn's Disease	☐	☐
Hepatitis	☐	☐
Ulcer / Reflux	☐	☐
Genito-Urinary		
Bladder / Genital / Kidney	☐	☐
Bones – Joints – Muscles		
Joint / Muscle Pain	☐	☐
Osteo Arthritis	☐	☐
Rheumatoid Arthritis	☐	☐
Lymphatic – Hematologic		
Anemia	☐	☐
Bleeding Problems	☐	☐
Psychiatric (Anxiety – Depression)	☐	☐

Medications

List all current prescription and over the counter medications

____

____

____

____

____

Medical Allergies

____

____

____

____

Tech Initials __________ Date ____________________ Dr. Signature ______________________________

Tech Initials __________ Review Date ______________ Dr. Initial __________

Tech Initials __________ Review Date ______________ Dr. Initial __________

Tech Initials __________ Review Date ______________ Dr. Initial __________

Patient Financial Responsibility and Assignment of Benefits

1. Financial Responsibility. I agree to pay VisionFirst and its assigns, for any and all services rendered or expenses incurred as the responsible person on this account. I understand that bills are payable in full upon the rendering of treatment, however, VisionFirst will bill any applicable insurance as a courtesy. I assign VisionFirst all benefits due me for services rendered and expenses incurred under any applicable policy of insurance. I understand that I am financially responsible to VisionFirst for all charges and services not covered by this assignment, and promise to pay any remaining balance.

2. Collection Policy. An account is considered delinquent when insurance has not paid within 30-45 days after VisionFirst's billing, or if payment in full has not been received within 30 days of the final insurance payment. Delinquent accounts will be assessed penalties and interest at the annual rate of 12%, and may be turned over to a collection agency. I further agree that in the event legal action is required in order to enforce payment on this account, I will pay all court costs, expenses, attorney's fees and other costs incurred and/or expended as a result of such proceeding.

3. Continuing Services. I understand that VisionFirst may create a separate account for each time which services or expenses are incurred on this account, and I acknowledge and agree that the terms and conditions in this Financial Responsibility and Assignment of Benefits as outlined above shall be effective for continuing and additional services incurred after execution of this form.

Policyholder is defined as the employee who subscribes to the insurance plan through their employer.

____
Patient Name

____
Patient Signature

____
Parent or Legal Guardian Signature

Patient Relationship to Policyholder

Self Spouse Child

____
Policyholder (employee)

____

____
Policy Holder's Address (if different)

____
Place of Employment

INSURANCE INFORMATION

____
Medical Insurance Plan

____
Policyholder SS#

____
Med. Insurance Policyholder's Name

____
Policyholder's Date of Birth

____
Vision Insurance Plan

____
Policyholder SS#

____
Vision Insurance Policyholder's Name

____
Policyholder's Date of Birth

Patient Name: ______________________________

Address: ______________________________

Date of Birth: ______________________________

Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, ____________________, understand that as part of my health care, Visionfirst originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Visionfirst is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Visionfirst reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Visionfirst change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

____

____

____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I understand that I must give written permission for Visionfirst to disclose any information to my spouse or a family member. I hereby, give Visionfirst permission to disclose my personal health information to:

List of names we can call.

Name ______________________________ Phone ____________________

Name ______________________________ Phone ____________________

Name ______________________________ Phone ____________________

OVER →

I fully understand and accept / decline the terms of this consent.

____
Patient’s Signature

____
Date

FOR OFFICE USE ONLY
[ ] Consent received by _____________________________ on ______________________.
[ ] Consent refused by patient, and treatment refused as permitted.
[ ] Consent added to the patient’s medical record on _____________________________.