Welcome to our office!

How did you learn about us?

❑ Previous patient ❑ Convenient location ❑ Newspaper ❑ Mailing ❑ Insurance

❑ Yellow pages (Which one?)_____

❑ Staff member (Name) _____ ❑ Friends/family (Name) _____

Your demographic information:

Responsible party (if minor) _____

Patient's last name _____ First name_____

Salutation ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. Patient's date of birth____/____/____ Age _____

Marital status ❑ Single ❑ Married Social Security # _____- ___-_____

Address_____ City _____State _____Zip code _____

Home phone_____ Occupation_____

Cell phone_____ Employer_____

Email_____ Work phone_____

Please help us to meet government mandated anonymous reporting requirements by providing your:

Race/Ethnicity:

❑ American Indian or Alaska Native

❑ Asian

❑ Black or African American

❑ Latino or Hispanic

❑ Native Hawaiian or other Pacific Islander

❑ White or Caucasian

❑ Other_____

Preferred language:

❑ English

❑ French

❑ German

❑ Spanish

❑ Other_____

Your insurance information:

Medical insurance_____ Insured name_____

Vision Insurance_____ Insured date of birth____/____/_____

Insured Social Security #_____ -____- _____

Reason for exam: _____

_____

Your health information:

Primary care physician's name_____ City_____

Please list medications_____

_____

_____

Medical history (check all that apply)	Patient	Family
High blood pressure	❑	❑
Diabetes	❑	❑
Heart problems	❑	❑
Lung problems	❑	❑
Thyroid problems	❑	❑
Medical allergy	❑	❑
Seasonal allergy	❑	❑
Other_____	❑	❑
Eye history (check all that apply):		
Injury	❑	❑
Surgery	❑	❑
Cataracts	❑	❑
Glaucoma	❑	❑
Lazy eye	❑	❑
Retina problems	❑	❑
Macular degeneration	❑	❑
Other_____	❑	❑

I currently wear:

❑ Glasses

❑ Distance only

❑ Reading only

❑ Lined bifocal

❑ No line bifocal

❑ Trifocal

❑ Contact lenses

❑ Daily wear

❑ Extended wear

❑ Soft

❑ Soft toric

❑ Hard

❑ Gas permeable

❑ Bifocal

❑ Monovision

Contact lens brand_____

I replace my contacts every_____

Contact lens solution that I use_____

Visual symptoms with eyewear:

❑ Distance blur

❑ Intermediate blur

❑ Near blur

❑ Problems with frames

❑ Problems with contacts

❑ Computer symptoms

❑ Double vision

❑ Glare at night

❑ Sensitivity to light

Review of Systems

Patient name:_____ Today's Date_____

Please check all that apply (past or present):

EYES
- ❑ Glaucoma
- ❑ Cataract
- ❑ Macular Degen
- ❑ Surgery
- ❑ Uveitis (or inflammation)
- ❑ Blurred Vision
- ❑ Double Vision
- ❑ Loss of side vision
- ❑ Glare/Light sensitivity
- ❑ Night blindness
- ❑ Haloes around lights
- ❑ Flashes or floaters
- ❑ Eye Fatigue or tired
- ❑ Eye pain or soreness
- ❑ Sandy,gritty feeling
- ❑ Dryness
- ❑ Foreign body sensation
- ❑ Eye or lid infection
- ❑ Burning
- ❑ Itching
- ❑ Excessive tearing
- ❑ Discharge
- ❑ Redness
- ❑ Other_____

ALLERGIC/IMMUNOLOGIC
- ❑ Drug allergy_____
- ❑ Environmental allergy
- ❑ Rheumatoid arthritis
- ❑ Lupus
- ❑ Primary Immune Disease
- ❑ Aquired Immune Disease
- ❑ Other_____

MUSCULOSKELETAL
- ❑ Fibromyalgia
- ❑ Muscular dystrophy
- ❑ Osteoarthritis
- ❑ Ankylosing Spondylitis
- ❑ Other_____

CARDIOVASCULAR
- ❑ Heart disease
- ❑ Hypertension
- ❑ Stroke
- ❑ Vascular Disease
- ❑ High Cholesterol
- ❑ Other_____

SMOKING STATUS
- ❑ Never smoker
- ❑ Current everyday smoker
- ❑ Current someday smoker
- ❑ Former smoker

GASTROINTESTINAL
- ❑ Crohn's
- ❑ Colitis
- ❑ Ulcer
- ❑ Digestive
- ❑ Liver disease
- ❑ Other_____

NEUROLOGICAL
- ❑ Multiple Sclerosis
- ❑ Epilepsy
- ❑ Alzheimer's
- ❑ Parkinson's
- ❑ Other_____

CONSTITUTIONAL
- ❑ Developmental disability
- ❑ Weight loss
- ❑ Fever
- ❑ Fatigue
- ❑ Other_____

GENITOURINARY
- ❑ STD(herpetic, chlamydia)
- ❑ Prostate cancer
- ❑ Ovarian cancer
- ❑ Kidney disease
- ❑ Other_____

PSYCHIATRIC
- ❑ Depression
- ❑ Anxiety (Panic) disorder
- ❑ Schizophrenia
- ❑ Bi-ploar
- ❑ OCD
- ❑ Other_____

EAR, NOSE, MOUTH, THROAT
- ❑ Upper respiratory infections
- ❑ Ear ache / infections
- ❑ Runny nose
- ❑ Sore throat
- ❑ Ringing/tinitis
- ❑ Other_____

HEMATOLOGIC/LYMPHATIC
- ❑ Anemia
- ❑ Large volume blood loss
- ❑ Leukemia
- ❑ Lymphoma
- ❑ Other_____

RESPIRATORY
- ❑ Asthma
- ❑ Bronchitis
- ❑ Emphysema
- ❑ COPD
- ❑ Lung cancer
- ❑ Other_____

ENDOCRINE
- ❑ Non-insulin dependent Diabetes
- ❑ Insulin dependent Diabetes
- ❑ Thyroid dysfunction
- ❑ Hormonal dysfunction
- ❑ Breast cancer
- ❑ Other_____

INTEGUMENTARY
- ❑ Eczema
- ❑ Rosecea
- ❑ Psoriasis
- ❑ Alopecia
- ❑ Other_____

Financial policy and responsibility

Vision Care Group provides full scope optometry services including routine vision care and medical eye care. Depending on the nature of your visit, we may bill your routine vision plan, your medical insurance plan or both. Please have your insurance cards and driver's license ready when you return this form to the reception desk.

Payment in full is expected at the time of service or placing an order. We accept cash, checks, all forms of credit and debit cards. A non-sufficient funds charge back fee of $30.00 will be charged to your account in the event your check is returned from the bank.

Because coverage varies widely from plan to plan, it is impossible for us to know the exact coverage on your individual plan. We will do our best to quote your portion of the services and materials provided on the day of service. Your insurance plan will provide us with an explanation of benefits and the exact amount they will cover for your date of service. Regardless of your plan coverage, you will ultimately be responsible for any copays, deductibles, denied claims, unpaid claims or non-covered items. You will be considered self pay if we are unable to verify your insurance benefits or obtain authorization prior to your visit. We are not providers for any HMO plans. If you have an HMO plan you will be considered a self-pay patient.

As a courtesy we will send a statement one time after we have received an explanation of benefits from your insurance company if there is any remaining amount due from you. This may take 6-8 weeks from the date of service so do not be surprised. Your portion is due upon receipt of this statement. If payment is not received within 30 days of this statement we reserve the right to charge a $10.00 per month re-billing fee. If we do not receive your payment or arrangements for payment within 120 days your account will be considered deliquent and will be placed on credit hold. No further service will be provided to any family member until the account is made current. You will be responsible for any additional fees incurred in attempt to collect any amount due.

I have read the above policy regarding my financial responsibility to Vision Care Group for providing optometric services to the above named patient or me. I certify that the information provided is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Vision Care Group. I agree to pay Vision Care Group the full and entire amount of all bills incurred by me or the above named patient, if applicable, any amount due after payment has been made by my insurance carrier. _____(initials)

I further authorize Vision Care Group to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment necessary to secure payment for services provided. _____(initials)

I acknowledge that the Notice of Privacy Practices is posted at the location in which I am receiving treatment and that I have read and understand the notice. I further acknowledge that I have the right to request a copy of the notice and one will be provided to me. _____(initials)

Signature_____ Relationship to patient_____

Date____/___/_____