The Vision Centers

Last Name: _____

First Name: _____ Sex (please circle): M F

Social Security Number: _____ Date of Birth: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Daytime Phone (if different): _____

Cell Phone: _____ May we text you: Y N

E-Mail Address: _____

Emergency Contact Name & Number: _____

How did you hear about us? _____

Marital Status: _____ Employment Status: _____

Employer: _____ Occupation: _____

Preferred Language: _____

Race:

- ☐ Native American/Native Alaskan
- ☐ Asian
- ☐ African-American
- ☐ Hispanic
- ☐ Native Hawaiian/Other Pacific Island
- ☐ Caucasian
- ☐ Decline to Answer

Ethnicity:

- ☐ Hispanic / Latino
- ☐ Not Hispanic / Latino
- ☐ Native Hawaiian/Other Pacific Island
- ☐ Decline to Answer

Communication Preferred (please circle): Email Telephone Postal Mail

Last Eye Exam: _____ Doctor: _____

Do you wear contact lenses currently? ☐ Yes ☐ No

If so, what brand(s)? _____

Are you interested in wearing contact lenses? ☐ Yes ☐ No

Do you experience eystrain or headaches while on the computer? ☐ Yes ☐ No

Insurance Information

Primary Insured (Person Responsible for Bill)

Vision Insurance (Primary) _____

Name_____

Address_____

City _____ State: _____ Zip Code: _____

Home Phone (_____)_____ Date of Birth:_____

Social Secuity Number _____ Insurance ID Number: _____

Employer _____ Phone (____)_____

Employer's Address _____ Occupation _____

Secondary Insured (Leave Blank if none)

Vision Insurance (Secondary) _____

Name_____

Address_____

City _____ State: _____ Zip Code: _____

Home Phone (_____)_____ Date of Birth:_____

Social Secuity Number _____ Insurance ID Number: _____

Employer _____ Phone (____)_____

Employer's Address _____ Occupation _____

Patient Health History

Primary Care Physician: _____ Date Last Seen: _____

Medical/Family History (use back of sheet if more space is needed)

Please list all your current medications (include over-the-counter meds, vitamins, and herbal supplements):

_____

_____

Please list all major surgeries (Eye surgeries included) as well as the year they were done:

_____

_____

Please list any allergic reactions to medications or eye drops:

_____

_____

Please indicate if any of the conditions apply to you or a family member (blood relatives only).

Disease/Condition	Yourself		Family Member		Relationship (Blood Relatives Only)
	Yes	No	Yes	No	
Cataract	☐	☐	☐	☐	_____
Glaucoma	☐	☐	☐	☐	_____
Macular Degeneration	☐	☐	☐	☐	_____
Retinal Detachment	☐	☐	☐	☐	_____
Eye Turn	☐	☐	☐	☐	_____

Other: _____

Women- Are you pregnant? ☐ Yes ☐ No

Are you nursing? ☐ Yes ☐ No

Please indicate below if you have or ever had problems with the following conditions (check "None" if appropriate):

Allergic/Immunologic
☐ None
☐ Lupus (SLE)
☐ Rheumatoid Arthritis
☐ Environmental Allergies
☐ Seasonal Allergies
☐ Other (i.e., Latex)

Ear, Nose and Throat
☐ None
☐ Sinusitis
☐ Upper Respiratory Tract Infection
☐ Other

Gastrointestinal
☐ None
☐ Crohn's Disease
☐ Colitis
☐ Acid Reflux/Ulcer
☐ Other

Skin /Integumentary
☐ None
☐ Eczema
☐ Rosacea
☐ Psoriasis
☐ Other

Psychiatric
☐ None
☐ Depression
☐ Bi-Polar
☐ Schizophrenia
☐ Other

Cardiovascular
☐ None
☐ High Blood Pressure
☐ Heart Disease
☐ Stroke
☐ Vascular Disease
☐ High Blood Cholesterol

Endocrine/Glands
☐ None
☐ Diabetes
☐ Hormone Dysfunction
☐ Thyroid Dysfunction
☐ Other

Respiratory
☐ None
☐ Asthma
☐ Bronchitis
☐ Emphysema
☐ Other

Muscle/Skeletal
☐ None
☐ Arthritis
☐ Fibromyalgia
☐ Ankylosing Spondylitis
☐ Other

Genital/Urinary
☐ None
☐ Urinary Tract Infection
☐ HIV Positive
☐ Herpes/Chlamydia
☐ Other

Hematologic/Lymphatic
☐ None
☐ Anemia
☐ Leukemia
☐ Bleeding Disorder
☐ Other

Neurological
☐ None
☐ Multiple Sclerosis
☐ Epilepsy
☐ Tremors
☐ Other

General Health
☐ None
☐ Weight loss/gain
☐ Fever
☐ Fatigue
☐ Trauma

Social
☐ Tobacco Use:
Current Smoker Former Smoker
☐ Non-Prescription Drugs_____
☐ Alcohol Consumption_____
☐ Weight_____ Height_____

Insurance Declaration

Please sign below: (1) to acknowledge that this form is current, and (2) that I represent that if I have insurance coverage and hereby authorize my carrier to pay and assign directly all benefits otherwise payable to me for the products and services described to The Vision Centers. I hereby authorize them to release and obtain all information necessary to secure payment of said benefits. It is not the responsibility of The Vision Centers to verify coverage, and I understand that coverage is not a guarantee of full payment. **If my insurance(s) fail to pay in full, I agree to pay all unpaid balances**. If litigation is instituted to collect any unpaid balance(s), I also agree to pay all costs incurred by The Vision Centers. I have read, understand, and agree to all terms and conditions stated above.

Contact Lens Examination Charge

In order to obtain a valid prescription for contact lenses, a contact lens examination/evaluation must be performed by the optometrist. It is performed every year in order to ensure you have the appropriate lens power and fit, and to be sure your eyes are healthy enough to wear (or continue to wear) contacts. The charge is either $30 ("sphere", or basic contacts) or $50 (for astigmatism contacts, monovision and multifocal lenses, or RGPs). Medically-necessary contact lens evaluations are more complex and those charges will be discussed when needed. These fees are payable at the time of service and may not be covered by insurance. The fees still apply even if you are unable to successfully wear the lenses.

If there are any problems with the powers and/or fit of the contacts, you have up to 90 days from the date of the original exam in order to be re-evaluated or re-fit at no charge (this does not include visits for eye infections or similar reasons). If there is a change in the prescription and/or brand, any boxes purchased from The Vision Centers that are un-opened, un-marked, and un-damanged may be exchanged at no charge.

Missed Appointment and Cancellation Policy

If you are unable to keep a scheduled appointment, please give 24 hours advance notice to ensure that you will not be charged the $25 cancellation fee. Thank you for your cooperation and understanding.

Acknowledgement of Receipt of Notice of HIPAA Privacy Practices

As our patient we want you to know that we respect the privacy of your Personal Health Information (PHI) and will do all we can to secure and protect it. It is our policy to properly determine appropriate uses of PHI in accordance with the governmental rules, laws, and regulations. When it is appropriate and necessary, we provide the **minimum** necessary information only to those we feel are in need of it regarding treatment, payment, or health care operations, in order to provide health care that is in your best interests. Under the law, they are not required to obtain patient consent to use this information.

You may refuse to consent to the use or disclosure of your personal health information, but this must be provided to us in writing. Under the HIPAA laws, we have the right to refuse to treat you should you choose to refuse to disclose your PHI.

By signing below you acknowledge that you have read and understand the notice of privacy practices and all policies described above.

Name of Patient (Print): _____ Date:_____

Signature of Patient or Parent/Patient Representative:_____

Relationship of Patient Representative to Patient: _____