Welcome to Our Office

Please have ALL insurance cards ready as we need to make a copy, as well as a photo ID.
Please print all information.

Patient's Name: _____ M F Other (circle one)

Date of Birth: _____

Preferred Language: _____ English _____ Spanish _____ French _____ Other

Email Address: _____

Home Phone #: _____

Work/Daytime Number: _____

Cell Phone #: _____ Texting OK? Yes or no (circle one)

Communication Preferences: _____ email ____ home _____ cell _____text cell

Occupation: _____Employer: _____

Race: (Check one)

___ American Indian or Alaskan Native
___ Asian
___ White
___Black or African American
____ Biracial
____ Hispanic or Latino
_____ Other
____ Decline

Ethnicity:

____ Hispanic or Latino
____ Native Hawaiian/Other Pacific Island
____ Not Hispanic or Latino
____ Decline

Insurance information:

Medical Insurance Information:

Primary Medical Insurance

Name of Medical Insurance: _____
Member ID #:_____ Group #:_____
Insurance Provider Phone Number: _____ (on back of card)
Policy Holder's Name: _____ DOB: _____ Full SSN: ____-___-_____
Policy Holder's Contact Number: (___)____-_____
Policy Holders address if different from yours: _____
_____

If you have Medicare, do you have parts A and B? Y or N

Secondary Medical Insurance:

Name of Medical Insurance: _____
Member ID #:_____ Group #:_____
Insurance Provider Phone Number: _____ (on back of card)
Policy Holder's Name: _____ DOB: _____ Full SSN: ____-___-_____
Policy Holder's Contact Number: (___)____-_____
Policy Holders address if different from yours: _____
_____

Vision Insurance Information:

Name of Vision Insurance: _____ Address: _____
Member ID #:_____ Group #:_____
Insurance Provider Phone Number: _____ (on back of card)
Policy Holder's Name: _____ DOB: _____ Full SSN: ____-___-_____
Policy Holder's Contact Number: (___)____-_____
Policy Holders address if different from yours: _____
_____

Medical History Questionnaire

Name: _____ Marital Status:_____ Today's Date: _____
Address: _____ Birth date: _____ Age: _____
City/State/Zip: _____ SSN_____
Responsible Party: _____ I was recommended by: _____
Address if different: _____
Who is your primary physician? _____ Approx. date of last exam: _____

Reason for today's visit; routine eye exam and/or any eye problems (red eye, itchy eyes, blurred vision, watery eyes, new glasses or contacts etc):

_____

_____

PREVIOUS EYE HISTORY: crossed eyes, lazy eye, flashes, floaters, persistent dryness, drooping eyelid, prominent eyes, glaucoma, macular degeneration, retinal disease, cataracts, eye infections, eye surgery or eye injury. If so, when?

_____

_____

FAMILY SYSTEMIC/OCULAR History: Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions. Please indicate maternal or paternal side of family.

Disease/Condition	No	Yes	Relationship to you
Asthma	□	□	_____
Arthritis	□	□	_____
Cancer	□	□	_____
_____			
Diabetes	□	□	_____
Heart Disease	□	□	_____
High Blood Pressure	□	□	_____
Kidney Disease	□	□	_____
Lupus	□	□	_____
Thyroid Disease	□	□	_____
Other _____			

Disease/Condition	No	Yes	Relationship to you
Crossed Eyes	□	□	_____
Blindness	□	□	_____
Cataracts	□	□	_____
Glaucoma	□	□	_____
Macular Degeneration	□	□	_____
Retinal Detach/Disease	□	□	_____
Eye turn/"lazy" eye	□	□	_____
Other _____			

MEDICATIONS/ALLERGIES:

Please list all medications you take (including oral contraceptives, aspirin, OTC medications, supplements and home remedies): You may also provide a separate sheet of listed medication if needed

_____

_____

Do you have any medication allergies? □ no □ yes If yes, please list:

_____

_____

Do you have any other allergies? □ no □ yes If yes, please list:

_____

_____

Are you currently pregnant and/or nursing? □no □yes

SOCIAL History: *This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.*

Do you drive? □no □yes
Do you currently, or have you ever used tobacco/cigarettes? □ no □ yes If yes, type/amount/how long:_____
Do you drink alcohol? □ no □ yes If yes, type/amount/how long: _____
Do you use other substances? □ no □ yes If yes, type/amount/how long: _____
Have you ever been exposed to or infected with: □Gonorrhea □Hepatitis □HIV □Syphilis □None
History of blood transfusions? □ no □ yes

Glasses History:

Have you ever worn glasses? _____ For: Distance, Near or Both (circle one)

Are you interested in a new pair of glasses? Yes No Maybe (circle one)

If so, for what type of activities: _____

Contact Lens History:

I am interested in contact lenses as a new wearer □

I currently wear contacts and would like them updated □ I have worn contacts in the past □

Brand/Type: _____ Brand/Type: _____

How often do you change them? _____ How long ago? _____

Problems: _____Solution/Care system: _____

If you are having any difficulties with your current glasses and/or contacts, please explain:

_____

_____

Review of Systems: Do **you currently, or have you ever had any problems** in the following areas? Please indicate current condition or history of:

SYSTEM	No	Yes	?	SYSTEM	No	Yes	?
ALLERGIC/IMMUNOLOGIC				**IMMUNOLOGIC**			
Allergies/Hay Fever	□	□	□	Lyme Disease	□	□	□
Other allergies:	□	□	□	Sjogren's Syndrome	□	□	□
Sarcoidosis	□	□	□	Auto-Immune Disease	□	□	□
CARDIOVASCULAR				**MUSCULOSKELETAL**			
High blood pressure	□	□	□	Muscle pain	□	□	□
Vascular disease	□	□	□	Joint pain	□	□	□
Heart disease	□	□	□	Rheumatoid Arthritis	□	□	□
High Cholesterol	□	□	□	Osteoporosis	□	□	□
CONSTITUTIONAL				**LYMPHATIC/HEMATOLOGIC**			
Fever, Weight loss/gain	□	□	□	Anemia	□	□	□
Sleep Apnea	□	□	□	Bleeding problems	□	□	□
Fatigue or Dizziness	□	□	□	Sickle Cell	□	□	□
ENDOCRINE				**NEUROLOGIC**			
Thyroid/Other glands	□	□	□	Seizures/Epilepsy	□	□	□
Diabetes	□	□	□	Parkinson's	□	□	□
Gout	□	□	□	Headaches	□	□	□
Graves's Disease	□	□	□	Migraine Headaches	□	□	□
GASTROINTESTINAL				Multiple Sclerosis	□	□	□
Diarrhea	□	□	□	Myasthenia Gravis	□	□	□
Horner's Syndrome	□	□	□	**PSYCHIATRIC**			
Constipation	□	□	□	Depression	□	□	□
Irritable Bowel Syndrome	□	□	□	Attention Disorder	□	□	□
Acid-Reflux	□	□	□	Multiple Sclerosis	□	□	□
GENITOURINARY				Alzheimer's	□	□	□
Sexually-Transmitted disease	□	□	□	Bi-Polar Disorder	□	□	□
Menopause	□	□	□	Personality Disorder	□	□	□
Prostate complications	□	□	□	**RESPIRATORY**			
EAR, NOSE, MOUTH/THROAT				Heavy Smoker	□	□	□
Sinus Congestion	□	□	□	Asthma	□	□	□
Dry Throat/Mouth	□	□	□	COPD	□	□	□
Runny Nose	□	□	□	Lung Cancer	□	□	□
Post-Nasal Drip	□	□	□	Emphysema	□	□	□
Chronic Cough	□	□	□				

*** If you answered YES to any of the above or have a condition NOT listed, please explain:**

_____

_____

_____

_____

Patient Financial Agreement

Patient Name _____ Date of Service _____

Authorization to Assign Insurance Benefits

Patient (or the policyholder if the patient is not the policyholder) hereby authorizes and directs that all medical benefits payable to or for the patient under the terms of any applicable insurance policy be paid directly to Advanced Vision Care. Patient agrees to sign any additional assignment of benefits form requested by Advanced Vision Care or any insurance company from time to time. Patient understands that he /she is liable to Advanced Vision Care, whether or not covered by insurance.

Authorization of Medicare Benefits

I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by Advanced Vision Care including physician services. I authorize any holder of medical and other information about me to release Medicare and its agents any information needed to determine these benefits for related services.

Agreement to Pay Advanced Vision Care Charges

Patient and guarantor (where applicable) agree that in consideration of the services to be rendered by or through Advanced Vision Care, each personally promises and obligates himself/herself to pay the amount of Advanced Vision care charges in accordance with its regular rates and terms. In the event of non-payment, patient and guarantor (where applicable) understand that such non-payment will be reported to credit reporting agencies and agrees to pay all reasonable costs of collection including attorney's fees.

Contact Lens Fitting and Evaluation

Routine eye exams do not include services related to contact lens fitting or evaluation. Contact lens fittings fees or evaluation fees are most likely not covered by insurance and therefore are the responsibility of the patient or guarantor.

No Show/Cancellation Fee

A $50 fee will be applied to my account for appointments that are missed or cancelled within 24 hours of my scheduled appointment time.

x_____ x_____

Signature of patient (or guardian) Signature of guarantor
(If different from patient or guardian)

_____ _____

Guarantor's relationship to patient date

Acknowledgement of Receipt of HIPAA

I acknowledge that I have reviewed a copy of Advanced Vision Care's Notice of Privacy Practices, and I may request a copy.

X_____ _____

Signature of patient (or guardian) date