

Welcome to Our Office

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

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

Today's Date: _____ SSN _____

Email Address: _____ Marital Status: _____

Home Phone #: _____ I was recommended by: _____

Work/Daytime Number: _____ Approx. date of last eye exam: _____

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

Communication Preferences: _____ email _____ home _____ cell _____ text cell

Address: _____

City/State/Zip: _____

Persons we are able to share your medical information with: _____ Date of Birth: _____

Preferred Language: _____ English _____ Spanish _____ French _____ Other

Occupation: _____ Employer: _____

Race: (Check all that apply)

____ American Indian or Alaskan Native

____ Asian

____ White

____ Black or African American

____ Biracial

____ Hispanic

____ 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: _____

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: _____

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):

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			
Seasonal/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lyme Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other allergies:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sjogren's Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CARDIOVASCULAR				MUSCULOSKELETAL			
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	LYMPHATIC/HEMATOLOGIC			
CONSTITUTIONAL				NEUROLOGIC			
Fatigue or Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ENDOCRINE				PSYCHIATRIC			
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gout	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Attention Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Graves's Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	PTSD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid/Other glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bi-Polar Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GASTROINTESTINAL				Alzheimer's			
Acid-Reflux	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Horner's Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Irritable Bowel Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
GENITOURINARY							
Prostate complications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Menopause	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Sexually-Transmitted disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
RESPIRATORY							
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Heavy Smoker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
COPD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Lung Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

Who is your primary physician? _____

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

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?

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:

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	Disease/Condition	No	Yes	Relationship to you
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____	Eye turn/"lazy" eye	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Blindness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	_____
			_____	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	Retinal Detach/Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____	Other _____			_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____				
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	_____				
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____				
Other _____							

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

Are you currently pregnant and/or nursing? no yes
 Do you drive? no yes
 Do you currently use tobacco/cigarettes? no yes If yes, type/amount/how long: _____
 Have you ever used tobacco/cigarettes? no yes If yes, type/amount/how long: _____
 Do you drink alcohol? no yes If yes, how often: _____
 Do you use other substances? no yes If yes, type/ how long: _____
 Have you ever been exposed to or infected with: (Check all that apply) Gonorrhea Hepatitis HIV Syphilis
 History of blood transfusions? no yes

Glasses History:

Have you ever worn glasses? _____ For: Distance, Near or Both (circle one)
 Do you wear sunglasses? Yes No
 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
 Brand/Type: _____
 How often do you change them? _____
 Solution/Care system: _____

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

Dr. Signature	
x _____	Date: _____.

Patient Financial Agreement & Privacy Practice Acknowledgement

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.

Acknowledgement of Receipt of Notice of Privacy Practice

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

X _____
Signature of patient (or parent/guardian if applicable)

Guarantor's relationship to patient

date