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__________ Gender________

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	?
ALLERGIC/IMMUNOLOGIC			
Seasonal/Hay Fever	□	□	□
Other allergies:	□	□	□
CARDIOVASCULAR			
High blood pressure	□	□	□
High Cholesterol	□	□	□
Heart disease	□	□	□
CONSTITUTIONAL			
Fatigue or Dizziness	□	□	□
Sleep Apnea	□	□	□
ENDOCRINE			
Diabetes	□	□	□
Gout	□	□	□
Graves's Disease	□	□	□
Thyroid/Other glands	□	□	□
GASTROINTESTINAL			
Acid-Reflux	□	□	□
Horner's Syndrome	□	□	□
Irritable Bowel Syndrome	□	□	□
GENITOURINARY			
Prostate complications	□	□	□
Menopause	□	□	□
Sexually-Transmitted disease	□	□	□
RESPIRATORY			
Asthma	□	□	□
Heavy Smoker	□	□	□
Emphysema	□	□	□
COPD	□	□	□
Lung Cancer	□	□	□

SYSTEM	No	Yes	?
IMMUNOLOGIC			
Lyme Disease	□	□	□
Sjogren's Syndrome	□	□	□
Auto-Immune Disease	□	□	□
MUSCULOSKELETAL			
Osteoporosis	□	□	□
Rheumatoid Arthritis	□	□	□
LYMPHATIC/HEMATOLOGIC			
Anemia	□	□	□
Sickle Cell	□	□	□
NEUROLOGIC			
Seizures/Epilepsy	□	□	□
Parkinson's	□	□	□
Migraine Headaches	□	□	□
Myasthenia Gravis	□	□	□
Multiple Sclerosis	□	□	□
PSYCHIATRIC			
Depression	□	□	□
Attention Disorder	□	□	□
PTSD	□	□	□
Bi-Polar Disorder	□	□	□
Alzheimer's	□	□	□

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
Asthma	□	□	____________________
Arthritis	□	□	____________________
Cancer	□	□	____________________
Diabetes	□	□	____________________
Heart Disease	□	□	____________________
High Blood Pressure	□	□	____________________
Kidney Disease	□	□	____________________
Lupus	□	□	____________________
Thyroid Disease	□	□	____________________
Other____________________			

Disease/Condition	No	Yes	Relationship to you
Eye turn/"lazy" eye	□	□	_________________
Blindness	□	□	_________________
Cataracts	□	□	_________________
Glaucoma	□	□	_________________
Macular Degeneration	□	□	_________________
Retinal Detach/Disease	□	□	_________________
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 known I may request a copy at any time.

x____

Signature of patient (or parent/guardian if applicable)

_________________________________ ____________________________

Guarantor's relationship to patient date