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 (dry eyes, 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	□	□	Lyme Disease	□	□
Other Allergies:	□	□	Sjogren's Syndrome	□	□
			Autoimmune Disease	□	□
CARDIOVASCULAR					
High Blood Pressure	□	□	**MUSCULOSKELETAL**		
High Cholesterol	□	□	Osteoporosis	□	□
Heart Disease	□	□	Rheumatoid Arthritis	□	□
CONSTITUTIONAL			**LYMPHATIC/HEMATOLOGIC**		
Fatigue or Dizziness	□	□	Anemia	□	□
Sleep Apnea	□	□	Sickle Cell	□	□
ENDOCRINE			**NEUROLOGIC**		
Diabetes	□	□	Seizures/Epilepsy	□	□
Gout	□	□	Parkinson's	□	□
Graves Disease	□	□	Migraine Headaches	□	□
Thyroid/Other Glands	□	□	Myasthenia Gravis	□	□
			Multiple Sclerosis	□	□
GASTROINTESTINAL					
Acid Reflux	□	□	**PSYCHIATRIC**		
Horner's Syndrome	□	□	Depression	□	□
Irritable Bowel Syndrome	□	□	Attention Disorder	□	□
			PTSD	□	□
GENITOURINARY			Bipolar Disorder	□	□
Prostate Complications	□	□	Alzheimer's	□	□
Menopause	□	□	Anxiety Disorder	□	□
Sexually Transmitted Disease	□	□			
RESPIRATORY					
Asthma	□	□			
Heavy Smoker	□	□			
Emphysema	□	□			
COPD	□	□			
Lung Cancer	□	□			

Who is your primary physician? _____

*** Do you have a condition not listed above? If yes, 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, and supplements): You may also provide a separate sheet of listed medications 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 or nursing? □no □yes

Do you drive? □no □yes

Do you currently use tobacco/cigarettes? □ no □ yes If yes, how many packs per day:_____

Are you a former smoker? □ no □ yes If yes, when did you quit:_____

Do you drink alcohol? □ no □ yes If yes, how often: _____

Do you use other substances? □ no □ yes If yes, please specify: _____

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: Reading Computer Sports Other:_____

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