Patient Information

First Name _____Middle Initial __ Last Name_____ Date of Birth __/___/_____

Address _____ City_____ State_____ Zip _____

Home Phone (_____) _____-_____ Cell Phone (_____) _____-_____ Email: _____

Insurance Information

Primary Vision Insurance _____ Vision Insurance ID _____

Secondary Vision Insurance _____ Secondary Vision Insurance ID _____

Medical Insurance _____ Medical Insurance ID _____

Primary Member's Name □ Self □Spouse/Partner/Parent/Guardian_____

Primary Member's Date of Birth ___/___/_____ Please indicate the last four digits of the primary member's social security number here _____

Primary Member's Employer _____

Health History

Height_____Weight_____Allergies_____

Medications _____

Please check any that apply:

Self Family

□ □ Cataracts
□ □ Diabetes
□ □ High blood pressure
□ □ Macular degeneration
□ □ Heart problems
□ □ Retinal degeneration
□ □ Stroke
□ □ Thyroid condition
□ □ Crossed eyes or lazy eye
□ □ Glaucoma
□ □ Asthma and/or allergies
□ □ Color blindness
□ □ Arthritis
□ □ Tuberculosis
□ □ HIV/Hepatitis
□ □ Cancer
□ □ Blindness
□ □ Neuromuscular Disease

Please check any that apply:

□ Poor night vision
□ Eye strain
□ Headaches
□ Blurry distance vision
□ Trouble reading
□ Itchy eyes
□ Discharge
□ Watering
□ Eye pain
□ Burning eyes
□ Sandy/dry eyes
□ Red eyes
□ Frustration with blinding glare
□ Sensitivity to bright lights
□ Flashes of light
□ Eye injury
□ Double vision
□ Spots or floaters in vision
□ History of wearing an eye patch
□ History of eye surgery

Please indicate how frequently you use:

Alcohol _____
Tobacco _____
Other recreational drugs _____

Would you like any of the following?

□ New glasses
□ Contact lenses
□ Safety glasses
□ Lasik
□ Dry eye therapy
□ Sunglasses

How did you hear about us?

□ A friend or family member
□ Insurance company
□ Online search
□ Location

Contact Lens Wearers

Renewing your contact lens prescription requires additional time, knowledge, and materials. Contact lens evaluations are a separate service from your routine eye exam. Most vision insurance plans do not cover contact lens evaluations because they are not considered medically necessary. If you would like to renew your contact lens prescription, or try contact lenses for the first time, please inquire at the front desk for additional information.

Privacy Policy

Vision Plus makes every effort to protect the privacy of our patients' health care information, and will only use your protected information for the purposes of providing excellent health care. We want our patients to be aware of their privacy rights, and of all possible uses of their confidential health information. Please request a copy of our HIPPA Law Compliance Notice at the front desk, and sign below to acknowledge that you are familiar with our privacy policy. We cannot decline healthcare services to you if you do not provide a signed acknowledgment of our privacy practices

Agreement

I consent to the release of any medical information necessary to process my insurance claim and authorize payment from my healthcare insurance to Vision Plus. I understand that I am responsible for payment of any charges not covered fully by my insurance benefits and any insurance claim not paid by my insurance 90 days after submission of the claim. I understand that no refund can be made on clinical procedures or services provided including comprehensive eye exams, refractions, contact lens fittings and medical office visits. I understand that refunds or exchanges for undamaged optical products, including frames, lenses, and unmarked and unopened boxes of contact lenses can only be made within 30 days of receiving the product.

Patient/Guardian Signature _____ **Date** _____/_____/_____