Welcome to Vision Tech Optometry Center

"Modern Eye Care, Old Fashion Caring"

All information provided below will remain confidential and will be used only in accordance with HIPPA regulations.

□ Mr. □ Mrs. □ Miss □ Ms. □ Rev. □ Dr. Date: _____

_____ _____
Patient name Nickname

_____
Address City State Zip code

_____ _____ _____
Date of birth Employer/School Occupation/Grade

_____ _____ _____
Social security number Spouse/Parent name Other family members who are patients

If you are a minor, who is responsible for your account? Name _____ Relationship _____

Address _____ Date of Birth _____

SS#_____ Phone _____ Work Phone _____Employer _____

Gender: □ Female □ Male
Preferred language: □ English □ Spanish □ Other_____
Race: □ African American □ American Indian □ Arab □ Asian □ Caucasian □ Hispanic □ Indian □ Other

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino

Which phone number can we use to reach you? □ Home □ Work □ Cell

Home _____ Cell phone _____ Work _____

_____
E-mail address

_____
Primary care physician & Street address

_____ _____ _____
Emergency contact name Phone number Relationship

How will you settle your account today? □ Cash □ Check □ Credit card

INSURANCE INFORMATION

Primary medical insurance _____ Secondary medical insurance _____

Subscriber name/Date of birth _____ Subscriber name/Date of birth _____

Subscriber ID# _____ Subscriber ID# _____

NEW PATIENTS ONLY

Who may we thank for referring you? _____

If not referred, how did you first hear about our office? □ Phone book □ Insurance list □ Saw sign/building □ Radio
□ TV □ Newspaper (which one?) _____ □ Web page (which web site?) _____
□ Other _____

Vision Tech Optometry Center
(Effective 08/01/2012)

SUMMARY OF FINANCIAL RESPONSIBILITY

Unless other arrangements are made, **payment for visit is due at the time of the service** (either full fee if you are paying privately, or your **co-payment** if we are billing your insurance company).

Insurance is billed as a service to our patients; however, insurance companies do no guarantee payment and if insurance payments are not received **within 90 days** of service, **responsibility for payment switches to the guarantor**. Office staff is available to discuss potential payment issues with you.

Cancellation policy
Twenty-four hour notice is required for a cancellation of scheduled appointments. You are subject to a charge of the following fees for appointments that you "no show" or cancel with less than 24 hour notice: **No show fee is $50.00**.

You are at risk of losing your privilege to receive care at Vision Tech Optometry Center if you "no show" or cancel for two appointments.

Please review the following:

I understand the insurance may be filed for me, but I am ultimately responsible for payment of fees regardless of insurance coverage.

I authorize the release of medical information required to process insurance claims and/or to Complete Treatment Plans/Reviews required by insurance or managed care companies.

I authorize payment for my insurance company to be made directly to the practice.

I understand that I am responsible for obtaining proper (pre)authorization from my insurance company. I accept responsibility for payment if authorization is not obtained.

I understand that I will be billed for any missed appointments unless I cancel at least 24 hours before my scheduled appointment. Charges for no shows and cancellations less than 24 hours are NOT covered by the insurance company.

I understand that mailed monthly bills are due to at the time of receipt. Any bill not paid will be turned over to a collection agency, unless other arrangements have been made. If my account becomes assigned to a collection agency, I agree to pay all cost of collection, including 25% agency fees, court costs and attorney fees.

Print Name: _____

Signed: _____ Date: _____

HIPAA Policy
I have reviewed a copy of the HIPAA privacy policy and can receive a copy at my request.

Signed: _____ Date: _____

Vision Tech Optometry Center

"Modern Eye Care, Old Fashion Caring"

Patient name: _____ Today's date: _____

REASON FOR VISIT: □ blurry vision □ eye pain □ tearing □ headaches □ itchy eyes □ burning eyes □ gritty eyes □ trouble seeing at night □ trouble w/ glare □ sensitive to light □ floaters □ flashes of light □ other_____

PATIENT'S REVIEW OF SYMPTOMS: (Please check all that apply. If none, please check 'None')

Constitutional
□ *None*
□ Fatigue Syndrome
□ Cancer _____
□ Developmental Disability
□ Other_____

Ear, Nose,Throat
□ *None*
□ Hearing Loss
□ Sinusitis
□ Dry Mouth
□ Laryngitis
□ Other_____

Neurological
□ *None*
□ Cerebral Palsy
□ Tumor
□ Multiple Sclerosis
□ Epilepsy
□ Stroke/CVA
□ Migraine
□ Other_____

Psychiatric
□ *None*
□ Depression
□ Bipolar Disorder
□ Anxiety Disorder
□ Attention Deficit
□ Other_____

Cardiovascular
□ *None*
□ Vascular Disease
□ Heart Disease
□ Congestive Heart Failure
□ Stroke/CVA
□ High Blood Pressure
□ Other_____

Respiratory
□ *None*
□ Sleep Apnea
□ Cigarette Smoker
□ Chronic Obstruction
□ Emphysema
□ Bronchitis
□ Asthma
□ Other_____

Gastrointestinal
□ *None*
□ Crohn's
□ Colitis
□ Ulcer
□ Acid Reflux
□ Celiac Disease
□ Other_____

Genitourinary
□ *None*
□ Kidney Disease
□ Prostate Disease/Cancer
□ Pregnant
□ Benign Prostate Hypertrophy
□ Herpes
□ Nursing
□ Chlamydia
□ Other_____

Musculoskeletal
□ *None*
□ Arthritis
□ Osteoarthritis
□ Fibromyalgia
□ Muscular Dystrophy
□ Ankylosing Spondylitis
□ Osteoporosis
□ Gout
□ Other_____

Integumentary
□ *None*
□ Rosacea
□ Eczema
□ Herpes Simplex/Cold sores
□ Psoriasis
□ Herpes Zoster/Shingles
□ Other_____

Endocrine
□ *None*
□ Type 1 Diabetes Mellitus
□ Type 2 Diabetes Mellitus
□ Hormonal Dysfunction
□ Thyroid Dysfunction
□ Other_____

Hematologic/Lymphatic
□ *None*
□ Anemia
□ Ulcer
□ Large volume blood loss
□ High Cholesterol
□ Other_____

Allergic/Immune
□ *None*
□ Drug allergies
□ Sjogren's Syndrome
□ Lupus
□ Rheumatoid Arthritis
□ Environmental Allergies
□ *Other*_____

LIST ALL CURRENT MEDICATIONS: (Use back of sheet if needed)

Name _____ Strength _____
Name _____ Strength _____
Name _____ Strength _____
Name _____ Strength _____

ALLERGIES

Medication Allergies

□ No known medication allergies
List names_____

Other Allergies (environmental, food)

□ No known allergies
List allergens_____

Date of last eye exam _____

Name of last eye doctor _____

PATIENT'S PAST OCULAR HISTORY □ *Negative*

Have you ever been diagnosed or treated for the following?
(Check all that apply)

□ Dry eye
□ Nystagmus
□ Retinal detachment
□ Keratoconus
□ Injury
□ Macular degeneration
□ Cataract
□ Glaucoma suspect
□ Glaucoma
□ Strabismus (eye turn)
□ Inflammatory disorder (ex. Iritis,uveitis, scleritis)
□ Patching
□ Surgery
□ Retinal degeneration
□ Retinal hole
□ Ambloypia (lazy eye)
□ Other_____

PATIENT'S SOCIAL HISTORY

Alcohol use? □ Yes □ No □ Unknown
Amount_____
Tobacco use? □ Yes □ No □ Unknown
Preference:
□ Cigarettes
□ Cigars
□ Pipe
□ Smokes other
□ Smokeless tobacco
Amount _____
Smoking Status: (Check one)
□ Unknown if ever smoked
□ Smoker, current status unknown
□ Never smoker
□ Former smoker
□ Current some day smoker
□ Current every day smoker
□ Heavy tobacco smoker
□ Light tobacco smoker

*Immediate is Parents, Siblings and Children

List Hobbies: _____

IMMEDIATE FAMILY MEDICAL HISTORY □ *Negative*

□ Thyroid Relationship_____
□ Cancer _____ Relationship_____
□ Diabetes Relationship_____
□ Hypertension Relationship_____

Circle which type if known: Hyper or Hypo

Circle which type if known: Type I or Type II

IMMEDIATE FAMILY OCULAR HISTORY □ *Negative*

□ Glaucoma Relationship _____
□ Cataracts Relationship _____
□ Macular degeneration Relationship _____
□ Glaucoma suspect Relationship _____
□ Severe nearsightedness Relationship _____
□ Amblyopia Relationship _____
□ Severe farsightedness Relationship _____
□ Strabismus (eye turn) Relationship _____
□ Retinal detachment Relationship _____
□ Dry Eye Relationship _____
□ Nystagmus Relationship _____

Do you wear contacts? _____

If so, which brand? _____

Which solution do you use? _____

How often do you get a new pair? _____