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 01/01/2018)

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/Reschedule Policy
We require at least 24 hours advance notice if you need to cancel or reschedule your appointment.

After One (1) No Show/Same day rescheduled appointment: You will receive a letter and a phone call informing you of the no show or same day rescheduled appointment. You will still be able to continue to receive medical services at Vision Tech Optometry Center.

After Two (2) No Shows/Same day rescheduled appointments: You will receive a second letter and phone call reminding you that this is your second no show or same day rescheduled appointment. You will still be able to receive medical services at Vision Tech Optometry Center.

After Three (3) No Shows/Same day rescheduled appointments: You will receive a third letter informing you that we are discharging you from our practice.

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 the cancellation policy outlined above.
- 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? _____