Welcome to West County Vision Center

Thank you for choosing our office for you eye care needs! Please take a moment to complete the following information. If you have any questions, please do not hesitate to ask.

First Name (Legal Name) _____ MI _____ Last Name _____ Preferred Name _____

Street Address _____ City _____ State _____ Zip Code _____

Home Phone Number _____ Cell Phone Number _____ Daytime Phone Number _____

Date of Birth _____ Social Security Number _____ Email Address _____

Emergency Contact Person _____ Relationship to Patient _____ Emergency Phone Number _____

Primary Care Physician _____ Primary Care Physician Phone Number _____

Preferred Pharmacy _____ Pharmacy Phone Number _____

Patient Status: ____Male ____Female ____Single ____Married ____Other_____

____Student ____Employed ____Retired ____Unemployed ____Other_____

Race:

____Asian ____African American ____American Indian ____Hispanic ____White ____Other ____Decline to Specify

Ethnicity:

____Asian ____African American ____Hispanic ____Not Hispanic ____White ____Other ____Decline to Specify

Vision Insurance Information:

Vision Insurance Company _____ Member's First and Last Name _____ Member's Date of Birth _____

Member's Social Security Number _____ Employer _____ Relationship to Member: ____Self ___Spouse ____Child ___Other

Medical Insurance Information:

Medical Insurance Company _____ Member's First and Last Name _____ Member's Date of Birth _____

Member Identification Number _____ Employer _____ Relationship to Member: ____Self ___Spouse ____Child ___Other

How were you referred to our office?

___Website ___Walk-in ___Insurance Listing ___Patient (Name)_____

___Doctor (Name)_____ ___Other_____

Patient Name_____

Health History:

Primary Care Physician and Practice Name_____

Address_____ Phone Number_____

What is the main reason for today's exam?_____ When was your last eye exam?_____

Previous and Current Eye Conditions: Please check all that apply

___Glaucoma
___Dryness
___Cataract(s)
___Redness
___Itching
___Tired Eyes
___Loss Of Vision
___Flashes of Light
___Color Blindness
___Double Vision
___Floaters or Spots
___Drooping Eyelid(s)
___Fluctuating Vision
___Loss of Side Vision
___Mucous Discharge
___Retinal Detachment
___Macular Degeneration
___Glare/Light Sensitivity
___Amblyopia (Lazy Eye)
___Infection of Eye or Lid
___Sandy or Gritting Feeling
___Eye Pain or Soreness
___Excess Tearing/Watering
___Foreign Body Sensation
___Blurred Near Vision
___Blurred Distance Vision
___Distorted Vision (Halos)
___Strabismus (Crossed Eyes)

Past Eye Surgery_____

General Health Conditions: Please check all that apply and explain

___Fever
___Headaches
___Allergies
___Migraines
___Anxiety
___Depression
___HIV Positive
___Heart Disease
___High Cholesterol
___Kidney Disease
___Muscles
___Bones
___Joints
___Respiratory (Asthma)
___Thyroid
___Diabetes
___High Blood Pressure
___Stroke
___Lupus
___Neurological_____
___Epilepsy_____
___Blood Disease(s)_____
___Skin_____
___Gastrointestinal_____
___Ear, Nose, Throat_____
___Cancer_____
Are you Pregnant?____ Are you Nursing?____

Past Injuries:_____

Past Surgeries:_____

Family History: Please check all that apply

	Mom	Dad	Brother(s)	Sister(s)		Mom	Dad	Brother(s)	Sister(s)
Amblyopia (Lazy Eye)	___	___	___	___	Arthritis	___	___	___	___
Blindness	___	___	___	___	Cancer	___	___	___	___
Cataract(s)	___	___	___	___	Diabetes	___	___	___	___
Color Blindness	___	___	___	___	Heart Disease	___	___	___	___
Glaucoma	___	___	___	___	High Blood Pressure	___	___	___	___
Macular Degeneration	___	___	___	___	High Cholesterol	___	___	___	___
Retinal Detachment	___	___	___	___	Kidney Disease	___	___	___	___
Strabismus (Eye Turn)	___	___	___	___	Lupus	___	___	___	___
Other_____	___	___	___	___	Stroke	___	___	___	___
Other_____	___	___	___	___	Thryroid Disease	___	___	___	___

Current Medications and Dosage:_____

Current Eye Drop(s):_____

Medicines that cause reactions or sensitivities:_____

Specific Allergies (pollen, dust, etc.):_____

A Notice to Our Patients:

All copays and payments are required at the time of service. Any previous balances from insurance payments are due at time of visit. You may be asked for all balances and copays to be paid before you are seen by the doctor.

All of the frames and lenses are custom made in your particular prescription, therefore these items **CANNOT** be refunded. Once the order is placed no refund of any kind can be given. We will do everything in our power to ensure that you love your glasses and love wearing them.

Annual supplies of contact lens boxes that were purchased from our office that are unopened and unmarked can **ONLY** be exchanged for the same brand/type of contacts in a different power within one year of purchase.

Please do not hesitate to ask any member of our staff for clarification or if you have any questions.

I have read the above payment policy and understand that I am responsible for all payments as stated above.

_____ _____ _____
Signature of Patient/Guardian Print Name of Patient Date

Authorization of release of Private Health Information (PHI) to person(s) other than patient

I, _____ would like the following person(s) to have access to my Private Health Information (PHI) upon their request:

_____ No one other than the patient will be allowed access to the patient's PHI

_____ Family members including (please include name and relationship to patient) and/or other individuals:

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Signature Date

(This document will remain valid until the patient sends request for change in writing to West County Vision Center)

Contact Lens Evaluation Fees

Dr. McReynolds prescribes high quality contact lenses to improve your vision and your lifestyle. Contact lenses are FDA regulated medical devices that can cause discomfort, infections, and even permanent vision loss if not cared for properly. New and existing contact lens wearers require additional time and testing during an eye examination to minimize the risk of serious eye problems. This additional testing is only done for contact lens wearers. Your contact lens evaluation and service fee includes:

- Specific curvature measurements of the cornea
- Evaluation of current and new lenses to insure optimal fit, vision, and comfort
- Medical assessment of the cornea, tear film, and conjunctiva as they relate to contact lens wear
- Instructions regarding safe contact lens wear, care, and proper solutions
- Contact lens follow up appointments for 60 days, after 60 days there will be an additional charge of $30 for each additional visit

If you have any questions, please do not hesitate to speak with Dr. McReynolds.

Insurance Signature on File

Please Read and Sign Below:

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I authorize payment of these benefits directly to West County Vision Center on my behalf for any services and materials furnished. I authorize any holder of medical information about me to release to the Centers of Medicare Services and its agents, any information needed to determine these benefits payable to related services. If I have other health insurance coverage, my signature authorizes release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as my agent, as above.

I agree to pay all copays, deductibles, co-insurances, and non-covered services as determined by my insurance company. I understand verification of eligibility is **not a guarantee of payment** as stated by my insurance company. I understand that if the outstanding balance is not paid in full within 90 days of service date or purchase date of a product it will be sent to a collection agency. I understand that I will be responsible for both the amount of the balance and the amount charged by the collection agency.

If the patient is a minor child, I certify that I am the minor's legal guardian and have the legal right to authorize medical treatment (documentation may be required).

_____ _____

Signature of Patient/Legal Guardian Date

HIPAA

I acknowledge that a copy of L. Michelle McReynolds, O.D. Notice of Privacy Practices has been made available to me.

_____ _____ _____

Signature of Patient/Legal Guardian Print Name Date