Welcome to V Vision!

Thank you for choosing us for your eye care needs. We are delighted to have you as a patient and appreciate the confidence you have placed in us. Please complete the following information. If you have any questions, please do not hesitate to ask.

O Mr. O Miss O Mrs. O Ms. O Male O Female

First Name _____ MI _____ Last Name _____ Preferred Name _____

Street Address _____ City _____ State _____ Zip _____

Social Security # _____ Date of Birth _____ Cell Phone _____ Day Phone _____

Email Address _____ Guardian _____ Person Responsible for Account _____

Occupation _____ Employer _____

Emergency Contact _____ Emergency Phone _____

Race: O African American O Alaska Native O Asian O Caucasian O Hispanic O Native Hawaiian O Decline to Specify

Ethnicity: O Hispanic O Native Hawaiian or Other Pacific Islander O Not Hispanic O Decline to Specify

Communication Preference (check all that apply): O Email O Text O Telephone Call O Postal

Preferred Language: O English O Spanish O Other _____

Whom may we thank for referring you?_____

Vision Insurance Information

Name of Insurance Company _____ ID #/ Primary Member's SSN _____ Patient Relationship to Insured: O Self O Spouse O Child O Other_____

Primary Member's Name _____ Primary Member's Date of Birth _____ Patient Status: O Single O Married O Widowed

Patient Status: O F/T Student O P/T Student O Employed

Medical Insurance Information

Name of Insurance Company _____ Member ID Number _____ Primary Member's Name _____ Primary Member's Date of Birth _____

Please Read and Sign:

I assign my medial/vision benefits to V Vision and authorize said assignee to release all information necessary to secure payment from my insurance company. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company, and that final determination can only be made when the claim is processed. As such, I understand that if some fees are not paid by my insurance, I am still responsible and will be billed for them. Accounts 90 days old are subject to collections and there will be a service charge for returned checks. In order to control billing costs and reduce the need to raise our fees, all copays, deductibles, and charges for non-covered services, as per my insurance contract, are due at the time that they are rendered. _____ _____

Signature Date

I acknowledge that I received a copy of V Vision's Privacy Policy.

_____ _____

Signature Date

Please list any person with whom we may discuss your health information

Name	Relationship	Phone
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please Read and Sign:

Would you like a more extensive ophthalmologic evaluation of the health of the eyes by extended ophthalmoscopy? This is crucial in determining the overall health of your eyes. We are able to do this by applying drops to the eyes. Please ask if covered by your insurance. If not, we offer the procedure at a discounted price of $45. Yes_____ No_____

Signature_____

***If any change in glasses/contact lens Rx occurs past a 90 day period, the patient will be responsible for another refraction and/or exam fee.

Signature:_____

***Disposable contact lenses may be returned within 30 days of purchase for in store credit if the boxes are unopened and not marked on. RGP lenses may be returned within 75 days of purchase for refund or in store credit. There is a $5 restocking fee associated with the return. If a contact lens order is canceled for any reason, there is a $5 return shipping fee.

Signature:_____

Patient History and Information

Name _____ Primary Care Physician and Clinic Name _____

Health History

What is the main reason for today's exam?_____ When was your last vision exam?_____
When was your last health exam?_____ How is your overall health? _____
Past Illnesses or Injuries:_____
Past Surgeries:_____
Are you pregnant or nursing?_____
Current Medications (prescription, over-the-counter, & vitamins)(include dosage, frequency, and how medication is administered):
_____ _____ _____ _____ _____
_____ _____ _____ _____ _____
Current Eye drops (include dosage, frequency):_____ _____ _____
Allergies (including drug, food, and environment):_____

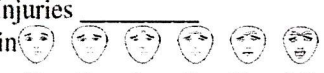
Social History

Do you engage in regular exercise? ○Yes ○No
Do you drink alcohol? If yes, how much/often: ○No ○ Occasional ○ 1 Per Day ○ 2-3 Per Day ○4+ Per Day
Do you smoke? If yes, how much/often: ○No ○ Occasional ○ ½ Pack/Day ○ 1 Pack/Day ○ 1+ Pack/Day
Method of Tobacco Intake: ○Smoking ○Chewing
Do you use illegal drugs? ○Yes ○No
Hobbies/Interests:_____

Eye History:

Do you currently, or have you ever had any problem with the following areas (circle all that apply):

Glaucoma	Loss of Central Vision	Color Blindness	Foreign Body Sensation	Distorted Vision (Halos)
Glaucoma Suspect	Loss of Side Vision	Infection of Eye/Lid	Sandy/Gritty Feeling	Double Vision
Cataract	Floaters or Spots	Mucous Discharge	Dryness	Blurred Vision Distance
Macular Degeneration	Flashes of Light	Excess Tearing/Watering	Glare/Light Sensitivity	Blurred Vision Near
Retinal Detachment	Eyelid Swelling	Itching	Amblyopia (Lazy Eye)	Fluctuating Vision
Vitreous Detachment	Blepharitis	Burning	Strabismus (Crossed Eyes)	Eye Injuries _____
Diabetic Retinopathy	Tired Eyes	Redness	Eye Pain/Soreness: Please rate pain	



General Health Condition:

Do you currently, or have you ever had any problem with the following areas (circle all that apply):

Constitutional:	Ears, Nose, Mouth, Throat:	Vascular/Cardiovascular:	Bones, Joints, Muscles:	Respiratory:	Immunologic:
Fever	Allergies/Hay Fever	Heart Pain	Arthritis	Asthma	AIDS/HIV
Weight Loss	Sinus Congestion	Vascular Disease	Muscle Pain	Chronic Bronchitis	Sjogren's Syndrome
Integumentary:	Runny Nose	High Blood Pressure	Joint Pain	Emphysema	**Psychiatric:**
Lupus	Post-Nasal Drip	Heart Disease	**Lymphatic/Hematologic:**	**Genitourinary:**	Anxiety
Rosacea	Chronic Cough	Stroke	Anemia	Kidney	Depression
Neurological:	Dry Throat/Mouth	**Gastrointestinal:**	Bleeding Problems	Genitals	ADD/ADHD
Headaches	**Endocrine:**	Chronic Constipation		Bladder	
Migraines	Thyroid	Chronic Diarrhea	Cancer: Type_____		
Seizures	Diabetes: Type _____	Hepatitis			

Family Health Condition:

Amblyopia (Lazy Eye)	Glaucoma	Cataracts	High Blood Pressure	Lupus	Thyroid Disease
Strabismus (Crossed Eyes)	Retinal Detachment	Blindness	Heart Disease	Kidney Disease	Cancer: Type_____
Macular Degeneration	Color Blindness	Arthritis	Stroke	Diabetes	Other _____

Spectacle Lens History:

Do you use a computer? ○Yes ○No How many hours/day?___
Do you drive? ○Yes ○No
Do you have glare problems? ○Yes ○No
Do you have problems with night driving? ○Yes ○No
Do you currently wear glasses? ○Yes ○No How long?_____
Type of glasses: ○Single Vision ○Bifocal ○Trifocal ○Progressive
Worn: ○Full Time ○Part Time ○Distance only ○Close only
Special Eyewear Needs: ○Computer (Special Rx, Anti-glare, Tints)
○Occupational (Pilots) ○Safety ○Sports/Hobbies

Contact Lens History:

If not a contact lens wearer, are you interested in trying contact lenses at this?
Have you ever tried to wear contact lenses? ○Yes ○No
Do you currently wear contact lenses? ○Yes ○No
Type and Brand of contact lenses:_____
Do you sleep in your lenses? ○Yes ○No
Do you have comfort problems in your current contact lenses? ○Yes ○No
Do you have vision problems in your current contact lens Rx? ○Yes ○No
If yes, ○Distance ○Near ○Both
What type of solution do you use?_____