

WELCOME TO OUR OFFICE!

PLEASE PRESENT ALL VISION AND MAJOR MEDICAL INFORMATION TO RECEPTIONIST

Please Print

Date _____ Patient's Full Legal Name _____ DOB ____/____/____ SSN# ____/____/____ Address _____ City/St _____ Zip _____ Country _____ Type of Address <input type="checkbox"/> Home <input type="checkbox"/> Office Home Phone _____ Cell Phone _____ Work Phone _____ Email _____ Note: It is now required we obtain an email address so we can upload your visit to the patient portal	Marital Status <input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> D <input type="checkbox"/> W Spouses Name _____ DOB ____/____/____ SSN# ____/____/____ Primary Language <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other Special Needs: <input type="checkbox"/> Hearing Impaired <input type="checkbox"/> Translator <input type="checkbox"/> Wheelchair Race <input type="checkbox"/> White <input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> Other _____ <input type="checkbox"/> Decline to Answer Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non-Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Decline to Answer Employer _____ Occupation _____ Last PCP Visit ____/____/____ PCP Doctor _____ Last Eye Exam ____/____/____ Prev. Eye Dr. _____
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Miscellaneous

List any previous surgeries with dates _____ _____ _____ Are You Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No Are You Breastfeeding? <input type="checkbox"/> Yes <input type="checkbox"/> No Hobbies/Recreational Sports you enjoy _____ _____ How many hours per day do you use a computer? _____	Do you wear glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you wear contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you interested in contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you interested in refractive surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you perform fine or close-up work? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you outdoors all or part of the time? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have trouble reading signs when driving at night? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you bothered by glare from: Overhead lighting? <input type="checkbox"/> Yes <input type="checkbox"/> No A computer screen? <input type="checkbox"/> Yes <input type="checkbox"/> No Oncoming headlights at night? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you sensitive in bright sunlight? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Review of Systems

Do you currently have, or have you ever had, any of the following problems or conditions?

	Yes	No		Yes	No		Yes	No
Constitutional			Gastrointestinal			Neurological		
Fever, Weight Loss/Gain	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular			Crohn's Disease	<input type="checkbox"/>	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis C	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer / Reflux	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric		
Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	Genito-Urinary			Anxiety / Depression	<input type="checkbox"/>	<input type="checkbox"/>
Ears/Nose/Mouth/Throat			Bladder / Genital / Kidney	<input type="checkbox"/>	<input type="checkbox"/>	Endocrine		
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Herpes Simplex	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes Type I	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	Prostate	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes Type II	<input type="checkbox"/>	<input type="checkbox"/>
Post Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal			Thyroid/Other Glands	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Joint / Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>	Lymphatic - Hematologic		
Dry Mouth/Throat	<input type="checkbox"/>	<input type="checkbox"/>	Osteo Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory			Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Integumentary (skin)			Allergic / Immunologic		
Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Skin Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Eczema	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Skin Disease	<input type="checkbox"/>	<input type="checkbox"/>	Hives	<input type="checkbox"/>	<input type="checkbox"/>
Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>	Herpes Zoster/Shingles	<input type="checkbox"/>	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	<input type="checkbox"/>
						Organ transplant	<input type="checkbox"/>	<input type="checkbox"/>

Ocular History

(mark yes or no to each question)

Age-related macular degeneration	<input type="checkbox"/> Yes <input type="checkbox"/> No	Injury to the eye region	<input type="checkbox"/> Yes <input type="checkbox"/> No
Amblyopia (Lazy eye)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Keratoconus	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blindness-one eye	<input type="checkbox"/> Yes <input type="checkbox"/> No	Retinopathy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blindness-both eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Strabismus (Crossed eyes)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tear film insufficiency (dry eyes)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other _____	
History of refractive surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	

Patient's Past Medical History

(mark yes or no to each question)

Acquired Immune Deficiency Syndrome (AIDS)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Human immunodeficiency virus infection (HIV)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hypercholesterolemia (high cholesterol)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hypertensive disorder (Hypertension)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seasonal allergy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chronic obstructive lung disease (COPD)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid dysfunction	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes mellitus	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mental disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatoid arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart disease	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Family Health History

(mark yes or no to each entry. If yes, list which family member including mother, father, brother, sister, maternal/paternal grandmother or maternal/paternal grandfather)

Amblyopia (Lazy eye)	<input type="checkbox"/> Yes <input type="checkbox"/> No _____	Strabismus (cross eyes)	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Blindness and/or vision impairment	<input type="checkbox"/> Yes <input type="checkbox"/> No _____	Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Cataract	<input type="checkbox"/> Yes <input type="checkbox"/> No _____	Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Macular Degeneration	<input type="checkbox"/> Yes <input type="checkbox"/> No _____	Diabetes mellitus	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No _____	Hypertension (high blood pressure)	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Retinal disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No _____	Cardiovascular disease	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
		Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No _____

Social History (check one for each question)

Are you a drug user? Yes No

Are you a: Non-drinker Social drinker

Tobacco Use (mark which one applies)

Heavy tobacco smoker Light tobacco smoker

Never a smoker Former smoker

Medications

List all **CURRENT** prescriptions, over-the-counter prescriptions, eye drops and dosages for each.

No Medications

Medication Allergies

List any allergies you may have and reaction.

No Medication Allergies

Tech Initials _____ Date _____ Dr. Signature _____

Tech Initials _____ Review Date _____ Dr. Initial _____

Tech Initials _____ Review Date _____ Dr. Initial _____

Tech Initials _____ Review Date _____ Dr. Initial _____



PATIENT FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS FORM

1. **FINANCIAL RESPONSIBILITY:** I agree to pay VisionFirst and its assigns, for any and all services rendered or expenses incurred as the responsible person on this account. I understand that bills are payable in full upon the rendering of treatment. However, VisionFirst will bill any applicable insurance as a courtesy. I assign VisionFirst all benefits due me for services rendered and expenses incurred under any applicable policy of insurance. I understand that I am financially responsible to VisionFirst for all charges and services not covered by this assignment and promise to pay any remaining balance.
2. **COLLECTION POLICY:** An account is considered delinquent when insurance has not paid within 30-45 days after VisionFirst's billing or if payment in full has not be received within 30 days of the final insurance payment. Delinquent accounts can be assessed penalties and interest at the annual rate of 12% and may be turned over to a collection agency. I further agree that in the event legal action is required in order to enforce payment on this account, I will pay all court costs, expenses, attorney's fees and other costs incurred and/or expended as a result of such proceeding.
3. **CONTINUING SERVICES:** I understand that VisionFirst may create a separate account for each time which services or expenses are incurred on this account. I understand that all professional services are not refundable but can receive refunds on the merchandise. I acknowledge and agree that the terms and conditions in this Financial Responsibility and Assignment of Benefits as outlined above shall be effective for continuing and additional services incurred after execution of this form.

ABOUT YOUR INSURANCE

There are two types of health insurance that may help pay for your eye care services and materials. You may have both and our practice accepts both: 1) Medical Insurance (such as Blue Cross/Blue Shield and Medicare) and, 2) Vision Insurance (such as VSP and EyeMed).

- Vision insurance only covers **ROUTINE VISION EXAMS** along with eyeglasses and contact lenses.
- Medical insurance **must be used** if you have any eye health problem that has ocular complications. Your doctor will determine if these conditions apply to you but some are determined by your case history.
- Most medical insurance plans do have routine vision screening benefits but these are very different than an actual vision examination. Vision screenings are basic screenings for eye disease. **They do not cover diagnosis, management or treatment of eye diseases nor do they allow for a prescription to be written for eyeglasses or contact lenses.**
- If you have both types of insurance plans, it may be necessary for us to bill some services to one plan and other services to the other plan. We will use coordination of benefits to do this properly and to minimize your out-of-pocket expense.
- We will bill your insurance plan for services if we are a participating provider for that plan. We will try to obtain advanced authorization of your insurance benefits in an attempt to let you know what is covered. Any co-pays, deductibles or non-covered services will be your responsibility.

I have read and understand the above policies.

PATIENT NAME:

Patient or Legal Guardian Signature

Date

**HIPAA OMNIBUS RULE
PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM FOR VISIONFIRST**

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date: _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:

(This includes your spouse, children, step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA?

First Name Only Proper Surname Other _____

PLEASE CIRCLE YOUR PREFERRED METHOD OF COMMUNICATION:

Home Phone Cell Phone Text Message Email

Can we leave automated appointment reminders on your home or cell phone? Yes or No

Can we leave messages letting you know your glasses and contacts are ready? Yes or No?

Do you give Visionfirst permission to import your medications from NewCrop Rx? Yes or No
(NewCrop is a software we use to send in electronic prescriptions to your pharmacy.)

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. MY SIGNATURE WILL ALSO SERVE AS A PROTECTED HEALTH INFORMATION DOCUMENT RELEASE SHOULD I REQUEST MY MEDICAL RECORDS BE SENT TO OTHER ATTENDING DOCTOR / FACILITY'S IN THE FUTURE.

Please print patients name

Please sign patients name

Legal Guardian

Date