PATIENT FORM

GENERAL INFORMATION

First, Last, MI, Preferred Name

Street Address, Unit #, City, State, Zip

Cell phone

Preferred Contact Method *cell phone* | *email* | *text* | *other (please explain)*

Email

Patient Social Security Number

Date of Birth

Male/Female

Marital Status *married* | *single* | *divorced* | *legally separated* | *widowed*

Occupation/Employer *full-time* | *part-time*

INSURANCE INFORMATION

Vision Insurance

Vision Insurance Member Name

Vision Insurance Member ID#

Vision Insurance Member Date of Birth

Primary Medical Insurance

Primary Member Name

Insurance ID#

Insurance Policy#/Group ID#

Primary Member Date of Birth

Primary Member Social Security Number

Primary Member Employer

Your Relationship to Primary Member *spouse* | *child* | *other (please explain)*

PATIENT FORM

EYE HISTORY

Date of Last Eye Exam

Reason for Today's visit

Currently Wear Glasses?

Currently Wear Contacts?

Type Daily/Monthly

Contact Lens Brand

Circle all that apply.

Cataracts	*yes*	*no*	*family*
Crossed Eye	*yes*	*no*	*family*
Glaucoma	*yes*	*no*	*family*
LASIK or RK	*yes*	*no*	*family*
Lazy Eye	*yes*	*no*	*family*
Macular Degeneration	*yes*	*no*	*family*
Retinal Detachment	*yes*	*no*	*family*

Are you currently experiencing, or have experienced, any of the following? Check all that apply.

- ☐ Blurry Vision *near or distance*
- ☐ Burning
- ☐ Discharge
- ☐ Double Vision
- ☐ Dryness
- ☐ Excess Tearing/Watering
- ☐ Eye Infection
- ☐ Eye Pain or Soreness
- ☐ Floaters or Spots
- ☐ Halos
- ☐ Headaches
- ☐ Itching
- ☐ Light Flashes
- ☐ Light Sensitivity
- ☐ Redness
- ☐ Sandy or Gritty Feeling

MEDICAL HISTORY

Have you or a family member experienced, or been treated for, any of the following? Circle all that apply.

AIDS/HIV	*yes*	*no*	*family*
Allergies	*yes*	*no*	*family*
Arthritis	*yes*	*no*	*family*
Asthma	*yes*	*no*	*family*
Blood/Lymph Disorder	*yes*	*no*	*family*
Diabetes	*yes*	*no*	*family*
Ears, Nose, Throat Conditions	*yes*	*no*	*family*
Gastrointestinal Conditions	*yes*	*no*	*family*
Heart Disease	*yes*	*no*	*family*
High Blood Pressure	*yes*	*no*	*family*
High Cholesterol	*yes*	*no*	*family*
Kidney Disease	*yes*	*no*	*family*
Lupus	*yes*	*no*	*family*
Neurological Conditions	*yes*	*no*	*family*
Psychiatric Disorder	*yes*	*no*	*family*
Seizures	*yes*	*no*	*family*
Skin Conditions	*yes*	*no*	*family*
Stroke	*yes*	*no*	*family*
Thyroid Dysfunction	*yes*	*no*	*family*

Current Medications
(Prescription and over-the-counter and dosage)

Medication Drug Allergies

Height **Weight**

Are you pregnant or nursing?

Do you smoke?

Have you ever smoked?

RELEASE OF INFORMATION

We respect our legal obligation to keep health information that identifies you private. ***Vision Source Magnolia*** maintains a Patient's Right to Privacy Policy that is displayed in our reception area. You may also request a copy for your records. The Policy describes how we protect your health information and what right you have regarding it. Your Signature below demonstrates that you understand and agree that regardless of insurance status, you are ultimately responsible for any balance of your account for services rendered; you authorized payment of medical claims to the provider; you are responsible for all charges not paid by insurance; you authorize the use of this signature on all insurance submissions.

I Hereby consent to a health examination, related diagnostic procedures and treatments provided by ***Vision Source Magnolia***. I hereby authorize my insurance company(s) to remit directly to ***Vision Source Magnolia*** all payment of benefits otherwise payable to me under the provision of my policy(s). I request that payment of authorized Medicare benefits be made either to me or on my behalf to ***Vision Source Magnolia*** for any services provided to me. I hereby authorize the release of this information needed to determine benefits payable for related services. I also authorize the use of any photographs or date collections taken to document my ocular condition for routine care or use in research and professional publication. Photo static copies of this authorization will be considered valid as the original.

We value the opportunity to communicate with our patients via email regarding appointment reminders, available in services, special offers, and the latest advances in the care of your vision. Be assured ***Vision Source Magnolia*** will not share your information with outside sources.

I give permission to ***Vision Source Magnolia*** to send me updated information on glasses, Contact lenses, reminder on Exam due date etc.

If my insurance company requires referrals, vouchers, or authorization, I will present these to the receptionist immediately. Failure to do so will made me responsible for full payment once services are rendered.

REFRACTION FOR EYE GLASSES IS NOT A COVERED MEDICARE SERVICE.

According to Medicare regulation, non-covered services may be billed to the patient if the services are considered to be Medicare program exclusions. Determination of a refractive state, (HCPCS code 92015) is program exclusion under Medicare; therefore, patients will be responsible to pay for that portion of the exam if refraction is done for new glasses.

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Patient/Guardian Signature Date