



1

PATIENT INFORMATION

Date _____

Patient _____

Address _____

_____ City _____ State _____ Zip _____

Sex: M F Age _____ Birthdate _____

Single Married Widowed Separated Divorced

Patient SS # _____

Occupation _____

Employer _____

Employer Address _____

Employer Phone _____

Spouse's Name _____

Birthdate _____ SS# _____

Occupation _____

Spouse's Employer _____

Whom may we thank for referring you? _____

2

INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

MEDICAL INSURANCE

Name of Insurance _____

Member ID # _____

Subscriber Name _____

Employer _____

Birth date _____ SS# _____

Relationship to Patient _____

VISION INSURANCE *ie. VSP, EYEMED, DAVIS*

Name of Insurance _____

Member ID # _____

Subscriber Name _____

Employer _____

Birthdate _____ SS# _____

Relationship to Patient _____

3

PHONE NUMBERS

Home _____ Work _____ Ext _____ Cell _____

Best time and place to reach you _____ e-mail address _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

Home Phone _____ Work Phone _____

4

EYE HEALTH HISTORY

<p>Previous Eye Dr. _____</p> <p>Date of last eye exam? _____</p> <p>Do you wear GLASSES? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> All the time <input type="checkbox"/> Occasionally <input type="checkbox"/> Reading <input type="checkbox"/> Driving <input type="checkbox"/> TV</p> <p>Do you wear CONTACTS? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Type _____ Hours/Day _____</p> <p>Describe any problems you have with your contacts _____</p>	<table border="0"> <tr> <td>Bloodshot Eyes</td><td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Headaches</td><td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Blurred Vision – Near/Far</td><td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Itching Eyes</td><td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Burning Eyes</td><td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Light Sensitive</td><td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Cataracts</td><td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Loss of Vision</td><td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Crossed Eyes</td><td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Migraine Headaches</td><td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Discharge from Eyes</td><td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Night Vision, Poor</td><td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Dizzy Spells</td><td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Red Eyes</td><td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Double Vision</td><td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Seeing Halos</td><td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Dry Eyes</td><td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Seeing Flashes</td><td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Eye Injury</td><td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Temporary Loss of Vision</td><td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Eye Strain</td><td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Vision Poor</td><td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Fainting Spells, Blackouts</td><td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Twitching Eyelid</td><td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Floaters or Spots</td><td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Watering Eyes</td><td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> </table>	Bloodshot Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blurred Vision – Near/Far	<input type="checkbox"/> Yes <input type="checkbox"/> No	Itching Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Burning Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Light Sensitive	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	Loss of Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	Crossed Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Migraine Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Discharge from Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Night Vision, Poor	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dizzy Spells	<input type="checkbox"/> Yes <input type="checkbox"/> No	Red Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Double Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seeing Halos	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dry Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seeing Flashes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Eye Injury	<input type="checkbox"/> Yes <input type="checkbox"/> No	Temporary Loss of Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	Eye Strain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vision Poor	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting Spells, Blackouts	<input type="checkbox"/> Yes <input type="checkbox"/> No	Twitching Eyelid	<input type="checkbox"/> Yes <input type="checkbox"/> No	Floaters or Spots	<input type="checkbox"/> Yes <input type="checkbox"/> No	Watering Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No
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IMPORTANT INFORMATION ABOUT CONTACTS

There is an additional charge for a Contact Lens Exam that most insurance companies will not cover. The fee for the contact lens evaluation can vary from \$25.00 - \$45.00 depending on the complexity of the fitting.

Additional testing for the evaluation includes:

Corneal curvature measurement, Corneal health evaluation, Proper fit of contacts: movement, centration, Review of solutions and wearing schedule, Follow up visits, Contact lens prescription.

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HEALTH HISTORY

Physician's Name _____ Date of last visit _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following. Also place a mark to indicate if a blood relative has had any of the following problems:

	Yourself		Family Members			Yourself		Family Members	
AIDS/HIV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis (Type _____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Joints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lazy Eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Migraine Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor Color Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Retinal Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chemical Dependency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shingles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drug Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin Conditions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Conditions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Turned Eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you Pregnant? _____	Number of children _____			
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco use _____	Alcohol use _____			
Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					

MEDICATIONS

List medications you are currently taking, including eye drops:

ALLERGIES

List your allergies to medications or other substances:

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FINANCIAL TERMS

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I authorize Jordan Vision Clinic to release any part of my medical record required to process an application for payment for services rendered or medical supplies delivered to my health insurance company or other third party payer.

AUTHORIZATION TO ASSIGN BENEFITS

I authorize and assign benefits from my health insurance company or third party payer to be paid directly to Jordan Vision Clinic.

GUARANTOR RESPONSIBILITY AND 3RD PARTY LIABILITY

I accept responsibility for payment of all charges resulting from my medical evaluation and treatment. This includes charges for medical evaluation, any medical procedure performed, medical supplies given or administered. Where the payment allowed by my health insurance for any service is less than the charge for that service. I agree to pay the balance of the full charge. I understand that payment is due at the time of service. I agree to pay any co-payment or deductible amount required by my health insurance policy at the time of service. I understand that an insurance claim form will be submitted to my primary health insurance company by the staff of Jordan Vision Clinic.

I agree to pay a monthly finance charge of 1.5% (18% annual interest rate) or \$2.00, which ever is greater on any balance on my account that is outstanding for over 90 days. I agree to pay a \$20 penalty fee for any check that I write that is returned for insufficient funds.. I agree to make payment in full for services performed within 90 days. I agree to make payment in full for services performed within 90 days of the date of service. I understand that failure to make payment within this time may result in the referral of my account to a collection agency. In the event that collection or legal action is taken by Jordan Vision Clinic to obtain payment for up to 40% of the total bill, with or without suit, attorney fees, court costs, and other expenses that result from such action

I accept responsibility for obtaining any written referral, or prior approval, or authorization for service required by my health insurance company or other third party payer. I agree to pay the full cost of any service which is either disallowed by health insurance company or which is not paid because such prior authorization was not obtained.

I certify that I have read this agreement and by my signature, I agree to the terms set forth above.

Guarantor's Signature _____ Date _____

Print Guarantor's name _____