Welcome Back to Visual Health

Today's Date:	Patient Name:	Date of Birth:	Sex: ❑ M ❑ F
Social Security Number:	Street Address:	City/State:	Zip:
Email Address:	Phone Number:	Best way to contact you: ❑ Email ❑ Phone	

Vision Insurance

Plan Name:	Policy Holders Name:
ID Number:	Policy Holders DOB:

Medical Insurance

Plan Name:	Policy Holders Name:
ID Number:	Policy Holders DOB:

❑ **Self-Pay: I am not using insurance at the time of service. I understand that I am responsible for any reimbursement from insurance.**

Reason for Todays Visit

❑ **Comprehensive Eye Exam:** Annual general health exam of the inside and the outside of the eyes. This will provide a new prescription for glasses. Please present your **vision insurance** information.

❑ **Comprehensive Eye and Contact Lens Exam**: If you are an existing contact lens wearer or new wearer, the doctor will evaluate or refit the lenses you are in and ensure they are satisfactory in fit and vision for another year. This will provide a new prescription for glasses and contacts. Please present your **vision insurance** information.

❑ **Medical Office Visit:** If you are experiencing: Irritated or painful red eye conditions, acute allergies, dry eyes, foreign bodies, or trauma, it should be investigated urgently. Abnormalities must be addressed before routine exams can be performed. Please present your **medical insurance** information and card.

Personal Medical History

- ❑ Allergies
- ❑ Arthritis
- ❑ Asthma
- ❑ Autoimmune
- ❑ Kidney Disease
- ❑ Lupus
- ❑ Migraine/headaches
- ❑ Neurological Disorder
- ❑ Psychiatric Disorder
- ❑ Respiratory Disorder
- ❑ Skin Conditions
- ❑ Thyroid Dysfunction
- ❑ Vascular
- ❑ **None**

Other Eye Information

- ❑ Blurred distance vision
- ❑ Blurred near vision
- ❑ Flashes of lights
- ❑ Light sensitivity
- ❑ Pain in eyes
- ❑ Double vision
- ❑ Dry eyes
- ❑ Discharge
- ❑ Floating spots in vision
- ❑ **None**

Other:

Family Medical History

Diabetes	❑ Yes	❑ No	❑ Self
Hypertension	❑ Yes	❑ No	❑ Self
High Cholesterol	❑ Yes	❑ No	❑ Self
Thyroid Disease	❑ Yes	❑ No	❑ Self
Cancer	❑ Yes	❑ No	❑ Self

Ocular History

Glaucoma	❑ Self	❑ Family	❑ No
Cataracts	❑ Self	❑ Family	❑ No
Macular Degeneration	❑ Self	❑ Family	❑ No
Retinal Detachment	❑ Self	❑ Family	❑ No
Blindness	❑ Self	❑ Family	❑ No

Current Medication: ❑ **None**

Allergies to Medications: ❑ **None**

Other Personal History

Are you pregnant? ❑ Yes ❑ No

Visual Field Screening

REQUIRED FOR DMV FORMS

Visual Field Screening is a computerized test that is used to assess the entire central and peripheral field of vision. We strongly recommend this test especially for patients who have a history of headaches/migraines, high blood pressure, diabetes, autoimmune disorders or for individuals who take high risk medications or have a family member who suffer from glaucoma or any retinal diseases.

Digital Retinal Photography

Fundus photography uses a high-resolution digital camera to take a detailed view of the back part of your eyes. It assists to detect and manage important diseases such as glaucoma, diabetes and macular degeneration. It is especially important for people with personal/family history of high prescriptions, high blood pressure, diabetes, retinal diseases, flashing lights, floaters or headaches.

❑ **Yes** **I elect to have retinal photos and a visual field screening; I understand there is a $90 charge that is not covered by insurance.**

❑ **Yes** **I elect to have retinal photos taken at this visit; I understand there is a $49 charge that is not covered by insurance.**

❑ No I have read the above information and decline retinal photos and a visual field screening at this time.

Signature: ______________________ Print Name: ______________________ Date: ____________

Insurance and Financial Agreement

I authorize payments from my insurance company to be made to Visual Health for services rendered. I authorize Visual Health to disclose my medical information to a third-party billing service for collecting payment to the extent necessary to allow responsibility for payment to be determined. **I understand that I am responsible for referrals needed before my appointment, co-pays, and if deductibles are not met, I must pay for that visit. I understand that I am responsible for presenting my insurance information at the time of service.** Regardless of my insurance status, I am ultimately responsible for the balance on my account.

Sign: ______________________ Date: ____________

OFFICE USE ONLY

Glasses:	Contact Lenses:
OD:	OD:
OS:	OS:

NCT: OD/OS Pre-Examiner/Temp: Visit Notes:

visual health
doctors of optometry