Welcome to Visual Health Doctors of Optometry

Today's Date:	Patient Name:	Date of Birth:

Social Security Number:	Preferred Name:	Occupation:	If under 18, guardians name:	Age:	Sex: ❑ M ❑ F

Street Address:	City/State:	Zip:	Phone Numbers: Cell:

Email:	Best way to contact you: ❑ Cell ❑ Email ❑ Work ❑ Home	Work: Home:

Vision Insurance

Plan Name:	Policy Holders Name:
ID Number:	Policy Holders DOB:
Group Number:	SSN of Policy Holder:

Medical Insurance

Plan Name:	Policy Holders Name:
ID Number:	Policy Holders DOB:
Group Number:	SSN of Policy Holder:

❑ **Self-Pay: I am not using insurance at the time of service. I understand that I am responsible for any reimbursement from insurance. I am also responsible to submit any claims on my own behalf. Visual Health is not responsible for back dating insurance that was not presented at the time of service.**

Reason for Todays Visit

❑ **Comprehensive Eye Exam:** General health exam of the inside and outside of the eyes. New prescription for any correction needed to be used with eye glasses. Please present your **vision insurance** information.

❑ **Comprehensive Eye Exam and Contact Lens Exam:** A fitting is done for new contact lens wearers, if the prescription of the contact lens has changed or if the doctor needs to change the material/brand of the contacts to enhance your vision. If you are an existing contact lens wearer, the doctor must evaluate the current lenses you are in and make sure they are still satisfactory in fit and vision for another year. Please present your **vision insurance** information.

❑ **Medical Office Visit:** Our doctors diagnose and treat a variety of ocular abnormalities. If you are experiencing: suddenly irritated or painful red eye conditions, acute allergies, dry eyes, foreign bodies, trauma, or sudden vision disturbances, it should be investigated urgently. **Often abnormalities must be addressed before routine exams can be performed**. Please present your **medical insurance** information and card.

Note to all Contact Lens Wearers

In most cases contact lenses and contact lens fittings are not considered "medically necessary" by insurances. Any tests performed to determine or update a contact lens prescription may not be covered in full by insurance and should this be the case the patient is responsible for exam fees. All contact lens follow up visits will be covered **within 90 days** of the original exam date, to avoid a $50 re-fit fee.

Insurance and Financial Agreement

I authorize payments from my insurance company to be made to Visual Health Doctors of Optometry for covered services rendered. I authorize Visual Health to disclose my medical information to a third-party billing service for the purpose of collecting payment for services rendered to the patient, to the extent necessary to allow responsibility for payment to be determined and payments and adjustments to be made. **I understand that I am responsible for referrals needed before my appointment**, **co-pays, and if deductibles 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.

Should timely payments of this account not be made, I authorize Visual Health Doctors of Optometry to retain the services of a collection agency to assist with the collection of any outstanding balance. Any expenses incurred by such an action shall become an additional liability for which I am responsible.

I certify that the information I have recorded with regard to my insurance coverage is correct. I further authorize the release of any necessary information, including medical information, to my insurance company in order to determine insurance benefits.

Print Name	Signature	Date

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Eye History

Date of last eye exam?

Currently have glasses?

Have you had corrective eye surgery?

How many hours do you use the computer?

How did you hear about us?

Contact Lens Information

Do you currently wear contacts?

Current brand of contacts?

What solution do you use?

Do you sleep in your contacts?

How often do you dispose of your lenses?

Are you trying contacts for the **first time** today?

Current Medication: ❑ **None**

Medication Drug Allergies: ❑ **None**

Other Personal History

Are you pregnant?	❑ Yes	❑ No
Do you currently drive?	❑ Yes	❑ No
Do you use tobacco products?	❑ Yes	❑ No
Do you drink alcohol?	❑ Yes	❑ No
Do you use other drugs?	❑ Yes	❑ No

Other:

Personal Medical History

❑ Allergies	❑ Neurological Disorder
❑ Arthritis	❑ Psychiatric Disorder
❑ Asthma	❑ Respiratory Disorder
❑ Autoimmune	❑ Skin Conditions
❑ Kidney Disease	❑ Thyroid Dysfunction
❑ Lupus	❑ Vascular
❑ Migraine/headaches	❑ **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

Other:

Ocular History

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

Other:

Other Eye Information

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

Other:

Visual Field Screening

REQUIRED FOR DMV FORMS

Visual Field Screening is a sophisticated computerized test that is used to assess the entire central and peripheral field of vision. Visual field testing can assist in early detection of diseases such as brain tumor, neurological diseases, glaucoma, optic nerve disorders, stroke or vascular problems before they become clinically detectable. We strongly recommend all of our patients receive this test. It's especially important 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 special high-resolution digital camera to take a detailed view of your retina, the back part of your eyes. It assists to detect and manage important diseases such as glaucoma, diabetes and macular degeneration. **Many eye and health conditions, if detected at an early stage, can be treated successfully without loss of vision.** Your retinal images will be stored electronically. This gives the Doctor a permanent record of the condition and state of your retina. We recommend that all of our patients receive this test. 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 digital 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: _____

Glasses: ❑ No presenting glasses **OFFICE USE ONLY** **Contact Brand, BC and DIA: ❑ No presenting contact info.**

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