VISION SOURCE™

WELCOME TO OUR OFFICE

Today's Date _____

Patient Information

Last _____
First _____MI _____
Street _____
City _____ State _____
Zip Code _____
Home Phone _____
Cell Phone _____ Text __Yes __ No
Date of Birth _____Age _____
Sex M F
Patient's SSN _____
Employer (or School) _____
Occupation (or Grade) _____
Spouse (or Parent's Name) _____
Spouse (or Parent's Work) _____

Email Address _____

What is the major purpose of this visit?

_____

Are you planning on getting new glasses today?
__ Yes __ No

Any problems with your current contact lenses or glasses?

_____

_____

VERY IMPORTANT! NEW PATIENTS ONLY:
Who may we thank for referring you to our office?
Name of friend or relative _____

If not referred, how did you choose our office?
❑ Google / Yahoo search
❑ Insurance List
❑ Saw Sign
❑ Facebook
❑ Yellow Pages book
❑ Yelp
❑ Website

At Vision Source of Howell, it is our mission to offer you the best eye care available. We do this by providing state-of-the-art care and outstanding customer service in a fun and friendly atmosphere. Our team of doctors and staff always recommend the most advanced products that are tailored to your individual needs and improve the quality of your vision. Finally, we guarantee that we will meet and exceed your expectations.

Insurance Information

Please note that insurance does NOT cover the Contact Lens Follow-Up Evaluation.

Vision Insurance_____
Subscriber Name_____
Subscriber SSN/ID_____
Subscriber Birth Date_____

Primary Medical Insurance_____
Subscriber Name_____
Subscriber SSN/ID_____
Subscriber Birth Date_____

Do you participate in a flex spending account?
❑ Yes ❑ No
How will you settle your account today?
❑ Cash ❑ Check ❑ Credit Card

Lifestyle Questions

Do you(r)……(check box if your answer is yes)
❑..eyes bother you while reading? while on computer?
❑..experience when reading: blur, double vision, moving?
❑..have interest in a non-surgical way to correct vision?
❑..have interest in a test drive of the latest contact lenses?
❑..spend time outdoors? _____hrs/week
❑..have prescription sunwear?
❑..prefer not to wear your glasses at times?
❑..want information on Laser Vision Correction surgery?
❑..have more than one pair of current Rx eyewear?
❑..have children? Ages ____ ____ ____ ____
❑..have family members in need of eyecare?

Have you ever experienced, been diagnosed or treated for any of the following?

❑ Blurry Vision
❑ Cataracts
❑ Crossed eye/Eye turn
❑ Eye Infections
❑ Flash of light
❑ Glaucoma
❑ Headaches
❑ Itchiness
❑ Macular Degeneration
❑ Retinal Detachment
❑ Tearing
❑ Uncomfortable glasses
❑ Other eye disorders_____
❑ Burning
❑ Corneal Abrasions
❑ Double Vision
❑ Eye Injury
❑ Floaters/Spots
❑ Grittiness
❑ Iritis/Uveitis
❑ Lazy Eye
❑ Occasional dryness
❑ Sunlight Sensitivity
❑ Trouble seeing at night

The information in this confidential case history form is critical to the evaluation of your vision and health.

Patient Medical History

Name of Family Physician_____
Town_____
Date of Last Physical Check-up_____

CURRENT MEDICATIONS (Rx or Over the Counter)
(List name of medications including eye drops, vitamins, & birth control pills)_____

_____

_____

Allergies to medications? ❑ Yes ❑ No
If so, what medications?_____

_____

Have you had any eye surgeries? ❑ Yes ❑ No
Do you use cigarettes/tobacco, alcohol, or other substances? ❑ Yes ❑ No

Have you ever been diagnosed or treated for the following health problems?	**Yes**	**No**
Allergies	❑	❑
Arthritis	❑	❑
Blood/Lymph	❑	❑
Bronchitis	❑	❑
Cancer	❑	❑
Cholesterol	❑	❑
Diabetes	❑	❑
Digestive	❑	❑
Ears/Nose/Throat	❑	❑
Endocrine	❑	❑
Eczema/Rashes	❑	❑
Fatigue	❑	❑
Fevers	❑	❑
Genitourinary	❑	❑
High Blood Pressure	❑	❑
Integumentary (Skin)	❑	❑
Kidney	❑	❑
Muscle/Bone	❑	❑
Neurological	❑	❑
Psychological	❑	❑
Respiratory	❑	❑
Sinus	❑	❑
Throat Infections	❑	❑
Thyroid	❑	❑
Unusual weight losses/gains	❑	❑

Patient Eye History

Date of Last Eye Exam_____
By Whom?_____

Have you ever tried contact lenses? ❑ Yes ❑ No

Do you currently wear contact lenses? ❑ Yes ❑ No
Interested in daily disposable contacts? ❑ Yes ❑ No
Experience end of day dryness? ❑ Yes ❑ No

Are you satisfied with the vision and comfort of your contact lenses? ❑ Yes ❑ No

Would you prefer clear contact lenses or colored contact lenses? ❑ Clear ❑ Colored

If you wear bifocals, do the lines or head tilting bother you? ❑ Yes ❑ No

Family Medical/Eye History (Check all that apply)

Is there a family medical history of any of the following:
❑ No ❑ Yes (Please check boxes)

	Relationship (Mother's or Father's side)
Blindness	❑_____
Cataracts	❑_____
Corneal Problems	❑_____
Diabetes	❑_____
Glaucoma	❑_____
Heart Disease	❑_____
Lazy Eye	❑_____
Macular Degeneration	❑_____
Retinal Problems	❑

ASSIGNMENT AND RELEASE

I, the undersigned, assign directly to this office all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am responsible for all copays and deductibles due on the day of service. If you are unable to make a payment on the day of service, we would like to inform you that it is our policy to add a $10 surcharge for any billing statements sent to collect on copays. This is to recuperate costs associated with processing, sending, and filing these statements. I understand that I am financially responsible for all charges not paid by insurance after 90 days. I hereby authorize the doctor to release all information to secure the payment of benefits. I authorize the use of this signature on all insurance submission.

Signature_____ _____
Responsible Party Signature Date

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