Insight Vision Center

WELCOME TO OUR OFFICE

Today's Date _____

Patient Information

Last _____
First _____MI ___
Preferred Name (if applicable)_____
Street _____
City _____ State _____
Zip Code _____
Date of Birth _____Age _____
Sex: M / F
Gender Identity _____
□ I prefer not to disclose.
Height_____ Weight_____
Home Phone _____
Cell Phone _____□ Texting Ok
Can we text you a survey after today's visit?
□Yes □No
Patient's SSN _____
Employer (or School) _____
Occupation (or Grade) _____
Spouse (or Parent's Name) _____
Spouse (or Parent's Work) _____
Email Address _____

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?
_____
Any other family member in need of eyecare?_____
_____

Insurance Information

Vision Insurance_____
Subscriber Name_____
Subscriber SSN_____
Subscriber Birth Date_____

Primary Medical Insurance_____
Subscriber Name_____
Subscriber SSN_____
Subscriber Birth Date_____

F.S.A. (Flex Spending Acct.) F9 Yes F9 No
F.S.A. &/or Insurance benefits can be used for glasses, sunglasses and contacts.

Reason for Examination

❑..I need new glasses
❑..I need new contacts
❑..I have an ocular health issue_____
❑..other_____

Ocular History

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

Medical History

Name of Family Physician_____
Date of Last Physical Check-up _____

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

Do you use tobacco? ❑ Yes ❑ No
Current smoking status_____
Do you drink Alcohol? ❑ Yes ❑ No
Amount _____

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

Are you currently pregnant? ❑ Yes ❑ No

Have you ever been diagnosed or treated for the following health problems?	**Yes**	**No**
Allergies _____	❑	❑
Arthritis	❑	❑
Cancer _____	❑	❑
Cholesterol	❑	❑
Diabetes	❑	❑
Digestive _____	❑	❑
Endocrine _____	❑	❑
Genitourinary _____	❑	❑
High Blood Pressure	❑	❑
Integumentary (Skin)_____	❑	❑
Neurological _____	❑	❑
Psychological _____	❑	❑
Respiratory _____	❑	❑
Sinus	❑	❑
Throat Infections	❑	❑
Thyroid	❑	❑
Unusual weight losses/gains	❑	❑

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

Patient Eye History

Date of Last Eye Exam_____
By Whom?_____

If you currently wear contacts OR are experiencing any problems with dry eyes, please fill out attached questionnaire.

Have you ever tried contact lenses? ❑ Yes ❑ No

Do you currently wear contact lenses? ❑ Yes ❑ No
What kind?_____
Solutions used_____

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

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	❑_____

HIPAA (Health Insurance Portability and Accountability Act of 1996)

This office is also committed to protecting your personal information and adheres to all Federal Privacy Guidelines. The HIPAA policies are posted in the office and you may request to have your own copy.

Please sign below once you have read and understand the included "NOTICE OF PRIVACY PRACTICES", indicating you are aware that this office complies with all HIPAA Privacy Guidelines.

_____ _____
Signature (parent/guardian) Date

Your Exam Today

Please be advised if you are using insurance coverage for today's visit, this is a contract between you and your insurance company...not Insight Vision Center.

If your insurance company has not reimbursed our office in full within 60 (or 90) days, you will be responsible for the remainder of the balance. Thank you for your consideration.

No Refunds are given for Professional Services.

ALL SALES ARE FINAL.

Signature:_____

Date:_____

Contact Lens Fitting Fee:

This fee covers the extra tests performed by the doctors along with any necessary follow-ups or trial lenses for **90 days**. These procedures are only done on patients that wear contacts; it is in addition to the services provided during the annual eye exam. **I, acknowledge that this procedure is a seperate fee and is not covered by my insurance unlesss otherwise noted:**

Signature:_____

Date: _____

iWellness Testing:

I have read and hereby agree to the terms and conditions of the iWellness exam to replace dilation for my visit today and every subsequent visit here after.

Signature: _____

Date: _____