ADVANCES IN SIGHT
VISION CENTER

Welcome

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you. We look forward to working with you in maintaining your health.

Patient Information

Name ._____ Soc. Sec #_____

Address_____

City_____ State _____ Zip _____ Phone_____

Email Address _____

Sex M F Age_____ Birth Date _____ Single Married Widow Separated Divorced

Patient Employed By _____ Occupation _____

Whom may we thank for referring you? _____

Primary Insurance

Person responsible for Account _____

Relation to Patient_____ Birth Date _____ Soc Sec # _____

Address (if different from patient)_____ Phone _____

City _____ State _____ Zip _____

Person responsible Employed by _____ Occupation _____

Business address _____Business Phone _____

Insurance Company _____Phone_____

Conrtact #_____ Group # _____Subscriber #_____

Patient Visual and Eye Health Information

What are the primary reasons for coming in today?_____

_____ _____

Date of last exam _____ Dilated ? Y N Do you wear glasses? Y N Do you wear CLs Y N

Have you had any eye injuries? Y N What/when_____

Have you had any eye surgery? Y N What/when_____

Do you have : Glaucoma? Y N Cataracts? Y N Dry Eyes? Y N Blurred Vision? Y N

Macular Degeneration? Y N

Do you have any other eye condition? Y N What/when_____

_____

Turn over and fill out the back

Medical Health and History Information

What is your general health?_____

Do you have any problems with any of these systems? (please circle all that apply)

Gastrointestinal	Y N	Nervous	Y N	Allergic/immunologic	Y N
Ears/nose/throat	Y N	Genitourinary	Y N	Mental	Y N
Respiratory	Y N	Musculoskeletal	Y N	Endocrine (glands)	Y N
Cardiovascular	Y N	Eyes	Y N	Integumentary (skin)	Y N
Constitutional	Y N	Blood/lymph	Y N		

Current Medication(s) _____

Are you allergic to any Medications? Y N List what happens _____

_____

Are you diabetic ? Y N What type _____ Date of Diagnosis _____

Any allergies ? Y N To what ? _____ What happens ? _____

Have you had General surgery ? Y N What/when _____

Do you use Cigarettes/tobacco ? Y N Alcohol ? Y N Other substances ? Y N Date of last tetanus shot _____

Name of family doctor _____Date of last visit _____

Do you have more than one pair of current Rx glasses ? Y N Do you work on a computer for long hours ? Y N

If you wear glasses would you benefit from thinner lighter lenses ? Y N Do you spend a lot of time outdoors? Y N

If you wear contact lenses are you satisfied with vision & comfort ? Y N Are you interested in laser correction? Y N

Family Visual History

High blood pressure Y N Relation_____ Diabetes Y N Relation_____

Macular Degeneration Y N Relation _____ Retinal Detachment Y N Relation_____

Glaucoma Y N Relation _____ Cataracts Y N Relation _____

Any Other Eye Conditions Y N What kind ?_____Relation_____

Authorization

I have reviewed the information on this questionnaire and it is accurate to my knowledge. I understand that this information will be used by the doctor to help determine appropriate treatment. If there is any change in my medical status I will inform the doctor.

I authorize my insurance company to pay the doctor or medical group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the doctor to release all information necessary to secure the payments of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

Payment is due in full at the time of treatment unless prior arrangements have been approved.