TOOELE VISION CENTER PATIENT INFORMATION

Name ____ Preferred Name________________________

Address____ City ________________State________ Zip ______________

Home Phone ________________________ Cell Phone________________________ Work Phone ______________________________

E-mail__________________________________ Please Notify Me By: ☐Home Phone ☐Work Phone ☐Cell Phone/Text ☐E-mail

Birthdate _____/_____/_____ Sex _______ Social Security Number ________-________-________ Marital Status____________

How were you referred to us? ____

RESPONSIBLE PARTY INFORMATION (If different than patient)

Name ____ Relationship to Patient: ________________________________

Address____ City ________________State________ Zip ______________

Birthdate _____/_____/_____ Sex _______ Social Security Number ________-________-________ Marital Status____________

Home Phone _______________________ Cell Phone______________________ Employer _________________________________

INSURANCE INFORMATION

VISION INSURANCE: ____

MEDICAL INSURANCE Primary: ______________________________________ Secondary: ___________________________________

MEDICAL HISTORY

Reason for todays visit: ____________________________________ Physician: _______________________

LIST ANY: Medications and Supplements____ Allergies_______________________

REVIEW OF SYSTEMS

Please circle any medical problems or concerns below:

EYES
Loss of vision
Blurred vision
Double vision
Eye injury
Eye surgery
Floaters/Flashes
Glare/Halos
Crossed or lazy eye
Cataracts
Glaucoma
Eye pain or soreness
Retinal disease

ENDOCRINE
Low Thyroid / Graves

BONES/JOINTS/MUSCLES
Joint pain / Arthritis

HEMATOLOGIC
Anemia

VASCULAR/HEART
Diabetes
High blood pressure
Cholesterol

NEUROLOGICAL
Headaches
Migraines

REPIRATORY
Asthma
Do you smoke? Yes / No

SKIN

PSYCHIATRIC
Depression / Anxiety

GASTROINTESTINAL
Stomach pain / Acid reflux
Crohn's

EAR/NOSE/THROAT/MOUTH
Allergies/Hay Fever

GENITOURINARY
Kidney / Bladder / Genital

FAMILY HISTORY

Please mark any family history of the following:

☐Blindness ☐Crossed Eyes ☐Glaucoma ☐Macular degeneration ☐Retinal detachment ☐Diabetes ☐Hypertension ☐Cataracts

I CURRENTLY WEAR:

☐ Eyeglasses ☐ Contact lenses ☐ Sunglasses

Regarding my *CURRENT* eyewear, I am ***DISSATISFIED*** with the: ☐Vision ☐Comfort ☐Look/Style ☐Computer Vision ☐Glare ☐Night

What types of hobbies do you enjoy or participate in?____

INSURANCE/HIPPA

I acknowledge that I have access to a copy of the office's Notice of Privacy Practices, and that my medical information will be kept confidential. I, the patient, KNOW MY INSURANCE COVERAGE. I authorize my insurance to be billed and I authorize payment to the physician herein for medical services rendered. I authorize the physician to release any information required in the processing of insurance. Co-payments and deductibles are due at time of service. I understand my deductible must be paid before my insurance will pay. My insurance may be billed for me but in the event insurance does not pay in full within 60 days for *any reason* all amounts due are my responsibility after that time and expected to be paid in full within 15 days. A service charge of 1.5% of the balance may be added to amount past due over 60 days and a service fee of $20 may be added for returned checks. Should my balance be turned over to a Collections Agency, the responsible party agrees to pay a collection fee of up to 40% and all legal fees of collection, with or without suit, including attorney fees and court costs. A photocopy of this signature is valid as the original.

I HAVE READ THE ABOVE POLICIES AND AGREE

SIGNATURE ____ DATE ___________________________