Vision PLUS NEW PATIENT REGISTRATION WELCOME TO OUR OFFICE

Patient Information

Today's Date ______________________

Last ______________________
First ______________________ MI ______
Street ______________________
City ______________________ State ___
Zip Code ______________________
Home Phone ______________________
Work Phone ______________________
SSN: ______________________
Date of Birth ______________ Age ________
Sex ❑ M ❑ F
Employer (or School) ______________________
Occupation (or Grade) ______________________
Spouse (or Parent's Name) ______________________
Spouse (or Parent's Work) ______________________

Email Address ______________________
(This is important to provide you with updated information about Vision PLUS. It will not be shared with any outside persons or sources.)

What is the major purpose of this visit?

____

Are you having any problems with your current contact lenses or glasses?

____

HOW NEW PATIENTS ARE REFERRED!

Whom may we thank for referring you to our office?
Name of friend or relative ______________________
If not referred, how did you choose our office?

- ❑ Another Dr.: If so, Who? ______________________
- ❑ Insurance List
- ❑ Office Signage/Building
- ❑ Newspaper/Yellow Pages/Radio/TV
- ❑ Web Page: Which Web Site? ______________________
- ❑ Other ______________________

The mission of Vision PLUS is to contribute to a lifetime of healthy vision, providing each patient with the highest quality vision care for the utmost in quality of life. We will seek continuing education to remain at the forefront of our profession and will offer the latest eye care technology, professional services, and products. The visual needs and wellness of each patient will always be our first priority. Everything we do shall communicate this.

Medical/Health Insurance Card Information

This office is a medical facility. Diseases of the body can show up in the eyes. If Dr. Wood determines the need for additional medical testing or treatment it will be filed to your medical insurance. Please give your card to the front desk staff for scanning into your medical file.

Vision Insurance ______________________

Major Medical Insurance(s) ______________________

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Method of Payment for Today's Visit:
❑ Care Credit (Payment Plan) ❑ Cash ❑ Check
❑ Credit Card ❑ Debit Card

Lifestyle Questions

Do you……(check box if your answer is yes)

- ❑..work at a computer? If yes, please complete computer questionnaire.
- ❑..think you might benefit from thinner, lighter lenses?
- ❑..have interest in a "test drive" of the latest contact lens designs
- ❑..spend time outdoors? How much? __Hrs/week
- ❑..have prescription sun wear?
- ❑..prefer not to wear your glasses at times?
- ❑..want information on Laser Vision Correction surgery?
- ❑..have interest in a non-surgical approach to vision correction?
- ❑..have more than 1 pair of current Rx eyewear?
- ❑..have children?
- ❑..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_______________________

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 yes, what medications?________________________
____

Have you had eye injuries or 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___________________________

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

Would you like to try progressive lenses? ❑ Yes ❑ No

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

Family Medical/Eye History (Check all that apply)

Is there a family medical history of any of the below? (Which family member)

Cataracts	❑	____________________
Corneal Problems	❑	____________________
Diabetes	❑	____________________
Glaucoma	❑	____________________
High Blood Pressure	❑	____________________
Lazy Eye	❑	____________________
Macular Degeneration	❑	____________________

This office is a medical facility, therefore it is important to have your insurance information and card(s) on file with us.

PATIENT GUIDELINES

FINANCIAL ASSIGNMENT (Signature Required Covers Entire Document)

-I understand that if during the course of my examination the doctor determines the need for medical testing & treatment, even though my insurance form states well vision, it will be filed to my medical insurance vice filed as a well visit and I will pay all co-pays, etc.

-I understand that I am financially responsible for all fees, and agree to reimburse any and all fees for services and materials not collected in full should my medical insurance or vision plan deny payment for services or materials rendered.

-I further understand that I agree to pay for any unpaid balances on my account as a result of denial in part or whole from my insurance carrier caused by denial of medical services, unmet deductibles, non-covered services i.e., refractions, or uncollected fees for prior services.

-If I do not inform you that I have a vision plan or medical insurance before services are rendered, it will be assumed that no coverage exists and I am responsible for all payments.

-I agree this office, NO EXCEPTIONS, will not back file claims or refund fees after services are rendered due to lack of notification of vision or medical insurance. It will be my responsibility to file my own claim and seek reimbursement from my insurance carrier.

-If I fail to reimburse said fees in a timely manner to Vision PLUS, and should the need arise, I agree to pay any and all collection fees, court costs, and attorney fees.

____ ____/______/______

Patient or Guardian /Signature Date

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Relationship to Patient

OFFICE POLICY

CONTACT LENSES: Due to the expense involved in contact lenses, i.e., Rigid Gas Permeable (RGP), Soft Torics, Specialty Contact Lenses, a fifty (50) percent deposit is due for the following: 1.) the patient is being prescribed the lenses* on a trial basis, 2.) the patient is placing an order for the contact lenses.

*If a patient is having difficulty and cannot wear the trial lenses, the patient will either receive a full refund, or apply the deposit to another lens.

DEPOSITS: Deposits are forfeited after thirty (30) days unless there is a valid reason.
WARRANTY: Insurance warranty one time replacement on all frames/lenses is good for one (1) year. **NO INSURANCE WARRANTY**: Frames/lenses, one time replacement, are good for (2) two years.
RETURN ON FRAMES OR LENSES: There is a thirty (30) day return policy.
RESTOCKING FEE: A charge due on refunds/returns deemed a specialty product.