Vision Source™
PATIENT INFORMATION

Date: _____ Appt. Date: _____ Appt. Time: _____ Birth Date: _____ Age: _____ ☐ M ☐ F

Patient's Legal Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone: Home _____ Work _____ E-Mail: _____ Contact me at: _____

Patient's S.S.I. #, Last 4 Digits: _____ Marital Status: ☐ S ☐ M ☐ W ☐ D Name you prefer to be called: _____

Occupation: _____ Employer: _____ Phone: _____

Spouse's Name: _____ **Parent's Names, if Patient is a Minor:** _____

Hobbies: _____

Please check the box that best describes you or your preference:

Preferred Language: ☐ English ☐ Spanish Communication Preference: ☐ Email ☐ Postal ☐ Telephone

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ African American ☐ East Indian ☐ Native Hawaiian/Pacific Is. ☐ White

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Referred to our office by: ☐ Physician ☐ Phone Book ☐ Advertisement ☐ Self ☐ Friend ☐ Other: _____

Other family members seen in this office: _____

INSURANCE INFORMATION: WE WILL MAKE A PHOTOCOPY OF YOUR CURRENT INSURANCE CARDS FOR OUR RECORDS.

Medical Insurance Co.: _____ Vision Insurance Co.: _____

MEDICATIONS
List medications you are currently taking and why, including OTC medicines and eye drops.

ALLERGIES
List allergies to medications or other substances.

EYE HEALTH HISTORY
Please circle all that apply.

Blurred Vision	Y	N	Sties or Infection of Lid	Y	N	Have you been diagnosed with or had:		
Redness	Y	N	Flashes/Floaters in Vision	Y	N	Dry Eye/Ocular Surface Disease	Y	N
Sandy or Gritty Feeling	Y	N	Loss of Vision, even temporary	Y	N	Chronic Eye Infection	Y	N
Itching	Y	N	Color Deficiency	Y	N	Cataracts	Y	N
Burning	Y	N	Crossed Eyes/Eye Turn	Y	N	Glaucoma	Y	N
Excess Tearing/Watering	Y	N	Eye Strain	Y	N	Macular Degeneration	Y	N
Glare/Light Sensitivity	Y	N	Seeing Halos	Y	N	Retinal Detachment	Y	N
Stringy Mucus In/Around Eyes	Y	N	Night Vision, Poor	Y	N	Diabetic Eye Problems	Y	N
Tired Eyes/Eye Fatigue	Y	N	Twitching Eyelids	Y	N	Refractive Surgery	Y	N
Foreign Body Sensation	Y	N	Loss of Side Vision	Y	N			
Contact Lens Discomfort	Y	N	Double Vision	Y	N			
Dryness	Y	N						
Use of Artificial Tears	Y	N						
Eye Pain or Soreness	Y	N						
Are above symptoms present in:								
Windy conditions?	Y	N						
Low humidity environment? (eg, airplane/hospitals)	Y	N						

Eye Injury, when: _____

Eye Surgery, when: _____

Other: _____

SYSTEMS REVIEW

*Do **You currently have** or **have you ever had** PROBLEMS in the following body areas. Please circle all that apply.*

INTEGUMENTARY, Skin	Y	N	GASTROINTESTINAL	Y	N	FAMILY HISTORY	
WEIGHT, Loss / Gain			KIDNEY / BLADDER	Y	N	Please note any family history and their relationship to you.	
NEUROLOGIAL			BONES / JOINTS / MUSCLES			Cataract, _____	
Headaches	Y	N	Rheumatoid Arthritis	Y	N	Crossed Eyes, _____	
Migraines	Y	N	Joint Pain	Y	N	Glaucoma, _____	
Seizures	Y	N	LYMPHATIC / MEMATOLOGIC			Macular Degeneration, _____	
THYROID / OTHER GLANDS	Y	N	Anemia	Y	N	Retinal Problem, _____	
MOTION SICKNESS	Y	N	Bleeding Problems	Y	N	Cancer, _____	
EARS, NOSE, THROAT			PSYCHIATRIC	Y	N	Diabetes, _____	
Allergies / Hay Fever	Y	N	HIV / AIDS	Y	N	Heart Disease, _____	
Sinus Problems	Y	N	ARE CURRENTLY:			High Blood Pressure, _____	
Chronic Cough	Y	N	Pregnant or Nursing	Y	N	Lupus / RA, _____	
Dry Throat / Mouth	Y	N	Wearing Glasses	Y	N	Thyroid Disease, _____	
RESPIRATORY			Wearing Contact Lenses	Y	N	Other, _____	
Asthma	Y	N	Type: _____				
Chronic Bronchitis	Y	N	Have you smoked cigarettes	Y	N		
Emphysema	Y	N	If yes, do you currently	Y	N		
VASCULAR / CARDIO			Do you drink alcohol	Y	N		
Diabetes	Y	N	Use other substances	Y	N		
Heart Problem	Y	N					
High Blood Pressure	Y	N					
High Cholesterol	Y	N					

ASSIGNMENT AND RELEASE OF INSURANCE PAYMENTS

I, the undersigned, certify that I (or my dependent) have insurance coverage with the company listed on this form and assign directly to Coos Bay Vision Center all insurance benefits, if any, otherwise payable to me, for services rendered from time to time. I understand that this assignment does not relieve me from responsibility for charges not paid by my insurance company. As a courtesy, we will bill your insurance.

I understand my health insurance may not pay for the services I am receiving. I am agreeing to pay for these services personally if not covered by my health plan.

Medicare Patients: Medicare may pay a portion of the exam fee, however, Medicare will **not** pay for the refraction fee.

Even though an insurance claim is pending, I will receive a statement each month if my account has an outstanding balance. A service charge of 1.5% will be imposed on all accounts 90 days past due. Coos Bay Vision Center cannot accept responsibility for collecting my insurance claim. I hereby claim responsibility for payment of my account from the date of service and understand that payment is expected in full by the time materials are dispensed.

A minimum $25.00 fee will be assessed for any NSF checks.

This document will be retained as a permanent portion of your medical records. It will be available upon request of your insurance company.

CONTACT LENS POLICY

A non-refundable contact lens fee will be applied to all patients desiring a contact lens prescription.

SHIPPING AND HANDLING

We would be happy to mail your contacts or other materials to you. A nominal fee for shipping and insurance will be charged for this service.

TIME OF SERVICE DISCOUNT / MULTIPLE CONTACTS OR GLASSES

A discount is offered to anyone who pays in full at the time of service.. This discount does not apply to any package deals or specials. Payment must be made in full at the time of service/order to qualify for this discount. Any person who orders two pair of complete glasses (lens and frame) from the same prescription, orders one year of contacts, or one year of contacts and one pair of glasses from the same prescription may receive a discount.

PATIENT SIGNATURE ON FILE | PARENT/GUARDIAN SIGNATURE ON FILE | DATE

HISTORY UPDATE

Please review this form and note any changes since your last visit. Initial and date each visit.

INITIAL/DATE | INITIAL/DATE | INITIAL/DATE | INITIAL/DATE | INITIAL/DATE | INITIAL/DATE | INITIAL/DATE