WELCOME TO OUR OFFICE

Please present all vision and medical information to front desk

Please print

Date_____
Patient's Name_____
DOB_____
Address_____
City/ST_____Zip_____
Home Phone_____
Cell Phone_____
Work Phone_____
Email_____

Primary Language: English__ Spanish__ Other__
Race: White____ African American_____
American Indian___Other_____
Decline to answer___
Occupation_____
Employer_____
Grade_____
Primary Doctor_____
Pharmacy_____

How did you hear about us: Dr. Greg's previous patient___I'm a previous patient___ Insurance___
Internet search___ Other_____ Coworker, Friend or Family_____
(Please provide name)

Are you a contact wearer? Yes___ No___

Current Medications	OTC/Vitamins	Eye Drops
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies to medications or
substances:_____

Tobacco Use
Never smoked___ Current Smoker: Daily___ Occasional ___ Smokeless___
Former smoker___ I quit smoking _____years ago.

Eye History (circle all that apply)
Eye Discharge Cataracts Macular Degeneration Eye Strain Eye Pain Glaucoma Lazy Eye
Iritis/Uveitis Retinal Detachment/Tear Redness Floaters/Spots Double Vision Foreign Body
Flashes of light Sensitive to light Dry Eyes

Health History (circle all that apply)
Diabetes I Diabetes II Pre-Diabetes Thyroid Disease High Blood Pressure Heart Disease
High Cholesterol Seasonal Allergies Rheumatoid Arthritis Sleep Apnea
Autoimmune disease_____
Cancer (type)_____
Pregnant? No___ Yes___ Number of weeks_____

Family History (mother * father * mgm * mgf * pgm * pgf * brother * sister * aunt * uncle)
Diabetes_____
Heart Disease_____
High Cholesterol_____
Hypertension_____
Thyroid Disease_____
Cataracts_____
Glaucoma_____
Mac Degen_____
Lazy Eye_____

Optional Fees

Contact Lens Exam: There is a separate fee for contact lens evaluation. Insurance companies do not normally cover this. Fee ranges from $45 to $65 for current contact wearers and $85 to $95 for first time contact wearers. ___**Yes,** I want a contact lens evaluation with my exam. ___**No,** I will only receive a prescription for eye glasses.

Optomap Retinal Screening: Will scan the back of your eye to evaluate the overall health of our retina, assist in the early detection of the eye disease and can take the place of dilation of the eyes. Dr. Paula Sorensen, Dr. Eryn Caudill, and Dr. Greg Sorensen believe this test is an essential part of the comprehensive eye exam for all patients. Screening is $39 and not billable to insurance. **Yes**____ or **No**____ for Optomap.

HIPAA Privacy: All medical offices must keep your information confidential. A copy of our privacy practices are on the back of the clipboard. ___**Yes**, I have received, read, and understood the HIPAA notice. ___ **No**, I will decline to receive a copy of the HIPAA policy.

Office Financial Policies: I understand In Vision Optical will help facilitate insurance benefits, but it is my responsibility to know the terms of my medical and/or vision coverage. I understand my medical and/or vision insurance may be billed depending on vision issues. I understand insurance co-pays, coinsurance, and deductibles are due at time of service and will be collected as required by my insurance company and the law. We will estimate these payments for you with the information given by your insurance company. Uninsured patient services are due at time of service.

We require payment of half down in order to process your eye wear order with the balance due at dispensing. We use private optical labs to process your prescription. This is a custom order. We are unable to accept returns for a full refund. The cancellation of any order is subject to fees incurred.

Signature_____ Date_____

Authorization for Release of Information to Family Members and Others

Patient name:_____ Date of birth:_____

Under HIPAA requirements we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to others you must sign this form. This form will only give information to family and others indicated below. I authorize In Vision Optical and Eye Care to release my medical and/or billing information to the following individual(s).

1._____Relation to Patient:_____
2._____Relation to Patient:_____
3._____Relation to Patient:_____

Patient information: I understand the right to revoke this information at any time. I understand that information disclosed to any above recipients is no longer protected by federal or state law and may be subject to redisclosure by the above recipient. You have the right to revoke this consent in writing.

Patient's signature:_____Date:_____
Print name:_____