WELCOME TO OUR OFFICE

Please present all vision and medical information to front desk

Please print

Date_____ Primary Language: English__ Spanish__ Other__

Patient's Name_____ Race: White____ African American_____

DOB_____ American Indian___Other_____

Address_____ Decline to answer___

City/ST_____Zip_____ Occupation_____

Home Phone_____ Employer_____

Cell Phone_____ Grade_____

Work Phone_____ Primary Doctor_____

Email_____ 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_____ Cataracts_____

Heart Disease_____ Glaucoma_____

High Cholesterol_____ Mac Degen_____

Hypertension_____ Lazy Eye_____

Thyroid Disease_____

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 your retina, assist in early detection of eye disease and can take 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.

HIPPAA 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 HIPPAA notice. ___**No,** I will decline to receive a copy of the HIPPA 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 HIPPAA 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:_____