WELCOME TO OUR OFFICE

PATIENT INFORMATION (PLEASE PRINT) **CONFIDENTIAL**

NAME (Mr, Mrs, Ms, Minor): DATE:

ADDRESS: AGE: BIRTH DATE:

CITY: STATE: ZIP: HOME PHONE: ( )

OCCUPATION: WORK PHONE: ( )

EMPLOYER/SCHOOL: CELL PHONE: ( )

SOCIAL SECURITY NUMBER:

PERSON TO CONTACT IN CASE OF EMERGENCY: PHONE: ( )

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT: RELATIONSHIP TO PATIENT:

ADDRESS: HOME PHONE: ( )

SOCIAL SECURITY NUMBER: CELL PHONE: ( )

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ☐ YES ☐ NO

INSURANCE INFORMATION

NAME OF **VISION PLAN**:

NAME OF INSURED: RELATIONSHIP TO PATIENT:

BIRTHDATE: SOCIAL SECURITY NUMBER:

NAME OF EMPLOYER: WORK PHONE: ( )

ADDRESS OF EMPLOYER: CITY: STATE: ZIP:

HEALTH INSURANCE COMPANY: ID#

INS. CO. PHONE# HOW MUCH IS YOUR DEDUCTIBLE?

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ YES ☐ NO IF YES, LIST:

INSURANCE ASSIGNMENT AND RELEASE

I HEREBY AUTHORIZE THE PHYSICIAN TO RELEASE ANY INFORMATION REQUIRED TO PROCESS THE CLAIM FOR THE PROFESSIONAL SERVICES AND DETERMINING INSURANCE BENEFITS PAYABLE FOR RELATED SERVICES. I ALSO AUTHORIZE MY INSURANCE BENEFITS BE PAID DIRECTLY TO THE PHYSICIAN AND I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR NON-COVERED SERVICES.

SIGNATURE OF PATIENT, GUARDIAN OR PERSONAL REPRESENTATIVE DATE

PLEASE PRINT NAME OF PATIENT, GUARDIAN OR PERSONAL REPRESENTATIVE RELATIONSHIP TO PATIENT

CURRENT INFORMATION

HAVE YOU EVER WORN GLASSES? Y / N HOW ARE THEY USED? FOR DISTANCE_____ NEAR_____ CONSTANT_____

APPROXIMATE DATE OF LAST EYE EXAM ____________________________BY DOCTOR/LOCATION ____________________________

HAVE YOU EVER WORN CONTACT LENSES? Y / N APPROXIMATE DATE OF LAST CONTACT LENS EXAM ________________

WHEN WAS THE LAST TIME YOU WORE CONTACT LENSES? ___________WHAT BRAND OF CONTACT LENSES ________________

YOUR REASONS FOR VISITING OUR OFFICE TODAY (PLEASE CHECK ALL THAT APPLY)

___ **ROUTINE EYE EXAM**
(NO SPECIFIC PROBLEMS)
___ LOST OR BROKEN GLASSES
___ WANT NEW GLASSES
___ BLURRED DISTANCE VISION
___ BLURRED NEAR VISION
___ HEADACHES- HOW OFTEN?
____

___ **MEDICAL EVALUATION**
___ EYES WATER
___ EYES BURN
___ EYES ITCH
___ EYES FEEL DRY
___ RED EYES
___ GLARE
___ PAIN

___ SEE "SPOTS"
___ SEE FLASHING LIGHTS
___ **CONTACT LENS EXAM**
__SOFT __DISPOSABLE __COLOR
__RGP (RIGID GAS PERMEABLE)
__BIFOCAL CONTACT LENSES
___ PROBLEMS WITH CURRENT CONTACT LENSES
___ OTHER: ________________________________

PATIENT MEDICAL HISTORY

PHYSICIAN ______________________________ OFFICE PHONE ( ) ____________

	YES	NO
1. ARE YOU UNDER MEDICAL TREATMENT NOW?	☐	☐
2. ARE YOU TAKING ANY MEDICATION(S) INCLUDING NON-PRESCRIPTION MEDICINE?	☐	☐
IF YES, WHAT MEDICATIONS ARE YOU TAKING?		
3. ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTIONS TO ANY DRUGS? IF YES, PLEASE SPECIFY.	☐	☐
4. DO YOU USE TOBACCO?	☐	☐
5. WOMEN ONLY:		
(A) ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT	☐	☐
(B) ARE YOU NURSING?	☐	☐
(C) ARE YOU TAKING BIRTH CONTROL PILLS?	☐	☐

	YES	NO
6. HAVE YOU EVER BEEN DIAGNOSED WITH:		
CATARACT	☐	☐
GLAUCOMA	☐	☐
MACULAR DEGENERATION	☐	☐
RETINAL DISORDER	☐	☐
UVEITIS	☐	☐
AMBLYOPIA (LAZY EYE)	☐	☐
STRABISMUS ("CROSSED" OR "WALL" EYE)	☐	☐
7. HAVE YOU EVER HAD ANY EYE SURGERY OR INJURY? IF YES, EXPLAIN: ____________	☐	☐
8. HAS ANYONE IN YOUR FAMILY EVER BEEN DIAGNOSED WITH:		
CATARACT	☐	☐
GLAUCOMA	☐	☐
MACULAR DEGENERATION	☐	☐

9. WHEN WAS YOUR LAST COMPLETE PHYSICAL? ____________

10. PLEASE INDICATE WHICH OF THE FOLLOWING APPLIES TO YOU. CHECK ONLY IF ANSWER IS YES.

☐ DIABETES	☐ KIDNEY DISEASES	☐ PSYCHIATRIC DISORDER
☐ HIGH BLOOD PRESSURE	☐ THYROID PROBLEM	☐ SEXUALLY TRANSMITTED DISEASE
☐ HEART ATTACK	☐ TUBERCULOSIS	☐ AIDS OR HIV INFECTION
☐ HEART DISEASE	☐ LEUKEMIA	☐ SARCOIDOSIS
☐ STROKE	☐ ANEMIA	☐ SICKLE CELL DISEASE
☐ ASTHMA	☐ FATIGUE	☐ CROHN'S
☐ EMPHYSEMA	☐ FAINTING/SEIZURES	☐ COLITIS
☐ HAY FEVER/ALLERGIES	☐ EPILEPSY/CONVULSIONS	☐ ANKYLOSING SPONDYLITIS
☐ ARTHRITIS	☐ RECENT WEIGHT LOSS	☐ ROSACEA
☐ RHEUMATOID ARTHRITIS	☐ CANCER	☐ ECZEMA/PSORIASIS
☐ LUPUS	☐ RADIATION THERAPY	☐ OTHER ____________
☐ LIVER DISEASE	☐ MULTIPLE SCLEROSIS	

I certify that I have read and understand the above information, to the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

X ______________________________

SIGNATURE OF PATIENT OR PARENT IF MINOR DATE

*PLEASE LIST ANY HOBBIES YOU MAY HAVE: ______________________________

THANK YOU FOR THE PRIVILEDGE OF ALLOWING US TO BE OF SERVICE TO YOU.

VISUAL FIELD SCREENING

New and highly sophisticated computerized instrument now enables us to provide a more thorough visual field screening analysis. This instrument checks for areas of loss of sight in the central retina. Visual field testing can assist in early detection of glaucoma, retinal problems and neurological diseases including optic nerve disorders or tumors located in certain areas of the brain.

An individual does not notice most visual field defects until very late stages.
Virtually all of the major causes of blindness in the United States can be detected by changes in the visual field.

We recommend that all of our patients receive this test as part of their comprehensive eye examination. The fee for the screening is $15.00. Please check the appropriate area below stating your preference and sign this form. If you have any questions, the doctor will be happy to discuss this in more detail.

- ☐ I WANT the visual field screening.
- ☐ I DECLINE the visual field screening.
- ☐ I would like to discuss this procedure with the doctor.

____ ____________________
SIGNATURE OF PATIENT, GUARDIAN OR PERSONAL REPRESENTATIVE DATE

*** PLEASE NOTE***

This test is a screening. It is possible that additional, more comprehensive visual field testing may be necessary based on the results of your vision analysis.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

Total Vision Optometric Center, P.C.
4565 Daisy Reid Ave Suite 108
Woodbridge, VA. 22192

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers; if applicable.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

____

Patient Name Date

____

Signature Relationship to Patient

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment of the *Notice of Privacy Practices*, but was unable to do so as documented below:

Date: ___________ Initials: ___________ Reason: ____