

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)

<input type="checkbox"/> ROUTINE EYE EXAM (NO SPECIFIC PROBLEMS)	<input type="checkbox"/> MEDICAL EVALUATION	<input type="checkbox"/> SEE "SPOTS"
<input type="checkbox"/> LOST OR BROKEN GLASSES	<input type="checkbox"/> EYES WATER	<input type="checkbox"/> SEE FLASHING LIGHTS
<input type="checkbox"/> WANT NEW GLASSES	<input type="checkbox"/> EYES BURN	<input type="checkbox"/> CONTACT LENS EXAM
<input type="checkbox"/> BLURRED DISTANCE VISION	<input type="checkbox"/> EYES ITCH	<input type="checkbox"/> <input type="checkbox"/> SOFT <input type="checkbox"/> DISPOSABLE <input type="checkbox"/> COLOR
<input type="checkbox"/> BLURRED NEAR VISION	<input type="checkbox"/> EYES FEEL DRY	<input type="checkbox"/> RGP (RIGID GAS PERMEABLE)
<input type="checkbox"/> HEADACHES- HOW OFTEN?	<input type="checkbox"/> RED EYES	<input type="checkbox"/> BIFOCAL CONTACT LENSES
_____	<input type="checkbox"/> GLARE	<input type="checkbox"/> PROBLEMS WITH CURRENT CONTACT LENSES
_____	<input type="checkbox"/> PAIN	<input type="checkbox"/> OTHER: _____

PATIENT MEDICAL HISTORY

PHYSICIAN _____ OFFICE PHONE (____) _____

- | | YES | NO | | YES | NO |
|--|--------------------------|--------------------------|--|--------------------------|--------------------------|
| 1. ARE YOU UNDER MEDICAL TREATMENT NOW? | <input type="checkbox"/> | <input type="checkbox"/> | 6. HAVE YOU EVER BEEN DIAGNOSED WITH: | | |
| 2. ARE YOU TAKING ANY MEDICATION(S)
INCLUDING NON-PRESCRIPTION MEDICINE?
IF YES, WHAT MEDICATIONS ARE YOU TAKING?

_____ | <input type="checkbox"/> | <input type="checkbox"/> | CATARACT | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | GLAUCOMA | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | MACULAR DEGENERATION | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | RETINAL DISORDER | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | UVEITIS | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | AMBLYOPIA (LAZY EYE) | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTIONS TO ANY DRUGS? IF YES, PLEASE SPECIFY.

_____ | <input type="checkbox"/> | <input type="checkbox"/> | STRABISMUS ("CROSSED" OR "WALL" EYE) | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | 7. HAVE YOU EVER HAD ANY EYE SURGERY OR INJURY? IF YES, EXPLAIN: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. DO YOU USE TOBACCO? | <input type="checkbox"/> | <input type="checkbox"/> | 8. HAS ANYONE IN YOUR FAMILY EVER BEEN DIAGNOSED WITH: | | |
| 5. WOMEN ONLY: | | | CATARACT | <input type="checkbox"/> | <input type="checkbox"/> |
| (A) ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT | <input type="checkbox"/> | <input type="checkbox"/> | GLAUCOMA | <input type="checkbox"/> | <input type="checkbox"/> |
| (B) ARE YOU NURSING? | <input type="checkbox"/> | <input type="checkbox"/> | MACULAR DEGENERATION | <input type="checkbox"/> | <input type="checkbox"/> |
| (C) ARE YOU TAKING BIRTH CONTROL PILLS? | <input type="checkbox"/> | <input type="checkbox"/> | 9. WHEN WAS YOUR LAST COMPLETE PHYSICAL? _____ | | |

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

- | | | |
|---|---|---|
| <input type="checkbox"/> DIABETES | <input type="checkbox"/> KIDNEY DISEASES | <input type="checkbox"/> PSYCHIATRIC DISORDER |
| <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> THYROID PROBLEM | <input type="checkbox"/> SEXUALLY TRANSMITTED DISEASE |
| <input type="checkbox"/> HEART ATTACK | <input type="checkbox"/> TUBERCULOSIS | <input type="checkbox"/> AIDS OR HIV INFECTION |
| <input type="checkbox"/> HEART DISEASE | <input type="checkbox"/> LEUKEMIA | <input type="checkbox"/> SARCOIDOSIS |
| <input type="checkbox"/> STROKE | <input type="checkbox"/> ANEMIA | <input type="checkbox"/> SICKLE CELL DISEASE |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> FATIGUE | <input type="checkbox"/> CROHN'S |
| <input type="checkbox"/> EMPHYSEMA | <input type="checkbox"/> FAINTING/SEIZURES | <input type="checkbox"/> COLITIS |
| <input type="checkbox"/> HAY FEVER/ALLERGIES | <input type="checkbox"/> EPILEPSY/CONVULSIONS | <input type="checkbox"/> ANKYLOSING SPONDYLITIS |
| <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> RECENT WEIGHT LOSS | <input type="checkbox"/> ROSACEA |
| <input type="checkbox"/> RHEUMATOID ARTHRITIS | <input type="checkbox"/> CANCER | <input type="checkbox"/> ECZEMA/PSORIASIS |
| <input type="checkbox"/> LUPUS | <input type="checkbox"/> RADIATION THERAPY | <input type="checkbox"/> OTHER _____ |
| <input type="checkbox"/> LIVER DISEASE | <input type="checkbox"/> 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 PRIVILEGE 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.
4160 Merchant Plaza
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: _____