

VISION CARE ASSOCIATES (704) 541-0468

Eyewear History

Parent/Guardian: _____

- Glasses
- Bifocals
- Trifocals
- No-line bifocal
- Soft contacts
- Rigid contacts

Name: _____

Social History

Address: _____

- Tobacco use
- Drug use
- Daily alcohol use
- Casual alcohol use
- Non-smoker
- No alcohol use
- No drug use
- HIV
- Hepatitis
- Other...

City, St: _____ Zip: _____

Phone(H): _____ (cell): _____

Birth date: _____ Sex: _____

Email: _____

Family History (parents, grandparents, siblings)

- Blindness
- Glaucoma
- Crossed Eyes
- Color Blind
- Macular Degen.
- Retina Disease
- Retina Detach
- Diabetes
- Heart Disease
- High BP
- Cancer
- Other...

VISION or PRIMARY INSURANCE

Ins Co: _____ #: _____

Insured: _____ DOB: _____

Relationship to insured: _____

Medical History (patient only) [check all that apply]

Constitutional: recent fever weight loss
 weight gain pregnant/nursing

Integumentary: skin condition eczema rosacea

Neurological: seizures migraine MS tremor

Endocrine: thyroid disease diabetes

Ears, Nose, Throat, allergies dry mouth deafness

Mouth: congestion mouth sores dizziness

Respiratory: asthma chronic cough emphysema

Cardiovascular: heart disease vascular disease
 high BP palpitations

Gastrointestinal: reflux liver disease irritable bowel

Genitourinary: kidney disease urinary problems

Musculoskeletal: arthritis muscle pain back pain

Blood/Lymph: anemia blood disorder cancer

Psychiatric: anxiety depression disoriented

Immunologic: rheumatoid lupus other autoimmune

Med Allergies: penicillin eye drops codeine
 sulfa Novocain other (list)

Other conditions...

Eyes:

- Cataracts
- Crossed Eyes
- Lazy Eye
- Dry Eye Syndrome
- Keratoconus
- Stye/Chalazion
- Uveitis/Iritis
- Glaucoma
- Retinal Disease
- Retinal Detach.
- Macular Degen.
- Color Blind
- Eye Injury
- Other...

Current eye symptoms:

- Blurred vision
- Loss of vision
- Distorted vision
- Loss of side vision
- Double vision
- Redness
- Sandy/gritty
- Itching
- Burning
- Excess tearing
- Light sensitive
- Eye pain
- Flashes
- Floaters
- Drooping eyelid
- Other...

Injuries / Surgeries / Hospitalizations:

- Lasik
- Cataract Surg.
- Heart Surg.
- Other...

Payment is required at the time of service. If we accept your insurance, we will bill it for you. **You are responsible for any copays, deductibles, and charges denied by your insurance. CONTACT LENS FITTING AND FOLLOW-UP CARE IS BILLED SEPARATELY FROM YOUR EYE EXAM.**

Your health information is protected by our privacy policy. I acknowledge that I have been offered a copy of Vision Care Associates' "Notice of Privacy Practices".

Signature: _____ Date: _____

SIGNATURE ON FILE FORM

TOP SECTION FOR MEDICARE ONLY / BOTTOM SECTION FOR PRIVATE INSURANCE

Name of Patient

HIC # (Medicare Policy #)

Name of Medigap Insurer

Medigap Policy #

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Vision Care Associates, OD, PA for any services furnished me by that provider. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

I request payment of authorized Medigap benefits be made to this provider and also authorize any holder of medical information about me to release to the above named Medigap insurer any information needed to determine benefits payable for services from this provider.

Patient's Signature

Date Signed

FOR OTHER PRIVATE INSURANCE

- I understand that my insurance is an agreement between my insurance company and me. I understand that I am responsible for my balance **regardless of my insurance benefits**. I also understand that I am responsible for any co-payments or any other portion indicated by my insurance carrier.
- I request that payment of covered medical expenses be made on my behalf to Vision Care Associates, OD, PA for any services furnished me by that provider.
- I authorize any holder of medical information about me to release to my insurance company any information needed to determine benefits payable for services from this provider.

Print Name

Patient Signature

Date Signed