Welcome to our office!

VISION SOURCE™ PONTIAC • FAIRBURY FAMILY EYE CARE • VISION CENTER

The People You Need to See!

Date _____/_____/_____

Last Name _____ First Name _____ Middle Initial _____

Title: Mr. Mrs. Ms. Dr. Other _____ Gender _____ Marital Status: Single Married Widowed Divorced

Birthdate _____/_____/_____ Social Security # _____ Driver Lic. # _____

Address _____ City _____ State _____ Zip _____

Home Phone _____

Cell Phone _____

Email _____

Occupation _____

Employer _____

Work Phone _____

Race: *American Indian* *Asian* *Black/African American* *Hispanic* *Native Hawaiian/Pacific Islander* *White*

Ethnicity: *Hispanic* *Native Hawaiian/Pacific Islander* *Non-Hispanic*

Preferred Language: *English* *Spanish*

First and Last names of immediate family who are patients in our office:

_____

_____

With whom besides yourself may we discuss your personal health related information (include name, relationship and contact phone):

1)_____

2)_____

HIPAA Privacy Practices — Acknowledgment of Receipt

I acknowledge that a Notice of Privacy Practices has been presented to me. I understand that "take home" copies are available at my request.

SIGNED: _____ Date _____/_____/_____

Medical Insurance — Primary: _____

Medical Insurance — Secondary: _____

Vision Plan: _____

We can bill some carriers for you. All others must pay at time of service. Payment is expected for all non-covered services you receive. Any balance remaining 90 days after submission to your insurance company becomes your responsibility.

Policyholder Information

Last Name _____ First Name _____ Middle Initial _____

Birthdate _____/_____/_____ Soc. Sec. # (Last 4 digits) _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Employer _____ Work Phone _____

Patient or Patient Representative: I authorize the release of information to my insurance company as necessary to process my claim. I authorize payment of benefits to Pontiac Family Eye Care, LLC for services I have received. I agree to pay all collection fees, court costs and reasonable attorney fees if I default on my account. I agree to pay a charge of $35.00 for any check that is returned by my bank. I permit a copy of this authorization to be used in place of the original.

SIGNED: _____ Date _____/_____/_____

The **iWellness Screening** is able to detect eye disease that could lead to severe vision loss. *Your doctor requires that all adults receive an iWellness Screening (Optomap + iVue) at every annual examination - even if you think you are seeing clearly.* The $44 screening fee is not typically covered by health insurance or vision plans; however, our experience has proven that this imaging is very important.
For those ages 5-39, we require *Optomap* ($34).

_____ (initial) I have read this statement.

Who can we thank for referring you to our office? _____

Please turn over to complete other side.

Personal Medical and Ocular History

Family Physician _____ Last Medical Exam _____ (year) Last Eye Exam _____ (year) (location)

Please mark all conditions you have been treated for or experienced:

Allergy
- ☐ Environmental

Cardiovascular
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ Congestive Heart Failure
- ☐ Arrhythmia
- ☐ High Cholesterol
- ☐ Stroke

Constitutional
- ☐ Greater than usual thirst
- ☐ Greater than usual urination

Ears, Nose, Throat
- ☐ Sinus Congestion
- ☐ Cold Sores
- ☐ Hearing Loss

Endocrine
- ☐ Diabetes-Type 1
- ☐ Diabetes-Type 2
- ☐ Thyroid Disease

Gastrointestinal
- ☐ Crohn's Disease
- ☐ Ulcerative Colitis
- ☐ Colon Polyps

Genitourinary
- ☐ Kidney Disease
- ☐ Sexually Transmitted Disease

Hematologic/Lymphatic
- ☐ Leukemia
- ☐ Anemia
- ☐ Breast Cancer
- ☐ Sickle Cell Disease

Immunologic
- ☐ Shingles
- ☐ Lyme Disease
- ☐ Sjogrens Syndrome
- ☐ Sarcoidosis

Integumentary
- ☐ Skin cancer
- ☐ Rosacea

Mental Health
- ☐ Anxiety
- ☐ Depression

Musculoskeletal
- ☐ Rheumatoid Arthritis

Neurological
- ☐ Alzheimer's
- ☐ Parkinson's
- ☐ Myasthenia Gravis
- ☐ Multiple Sclerosis
- ☐ Seizures
- ☐ Migraines
- ☐ Bell's Palsy
- ☐ Brain Tumor

Respiratory
- ☐ Asthma
- ☐ COPD
- ☐ Histoplasmosis
- ☐ Sleep Apnea

If you have a condition not listed above, please name or describe below:

_____

_____

List any eye related surgeries you have had:

_____

_____

_____

List all other **major** surgeries you have had:

_____

_____

_____

Provide us a prepared list of any Rx and "over the counter" medications or supplements you take, including dosages, or write them below.

_____

_____

_____

_____

_____

Do you have medication allergies? ☐ NO ☐ YES If yes, list medications:

_____

_____

Females: Are you pregnant or nursing? ☐ NO ☐ Pregnant:; Due Date: _____ ☐ Nursing

Tobacco use: ☐ Never ☐ Former smoker, stopped _____ years ago ☐ Current smoker, _____ packs/day ☐ Smokeless tobacco user

Alcohol use: ☐ None ☐ Social use only ☐ 1-2 drinks/day ☐ 3-4 drinks/day ☐ More than 4 drinks/day

Family History

Please mark any family history of the following conditions (parents, grandparents, siblings, or children; living or deceased) :

- ☐ Blindness
- ☐ Cataract
- ☐ Turned Eye (strabismus)
- ☐ Lazy Eye (amblyopia)
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Color "Blindness"
- ☐ Retinal tear or detachment
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Cancer
- ☐ Other _____