Welcome to Poway Vision Care

PATIENT INFORMATION

Name:____DOB:_______________Today's Date:_______________

Street Address:_________________________________Apt:__________ City, State & Zip: ________________________

Home Ph:_________________________Work Ph:_________________________Cell Ph:__________________________

Email Address:____

If you are a NEW PATIENT, who may we thank for referring you to our office?

□ Friend/Family (name)________ □ Insurance□ Walk-by □ Website□ Yellow Pages□ Other: ___________

INSURANCE INFORMATION

Vision Insurance:____Plan or Group Name or #:__________________

Subscriber:______________________________Subscriber DOB:_____________Subscriber ID or SSN:_______________

Subscriber's relationship to patient:____

Major Medical / Health Insurance:______________________________Plan or Group Name or #:__________________

Subscriber:______________________________Subscriber DOB:_____________Subscriber ID or SSN:_______________

Patient's relationship to subscriber: □ Self □ Spouse □ Child □ Other

Patient Status: □ Single □ Married □ Other

□ Employed □ Full-Time Student □ Part-Time Student

Primary Physician:____Dr.'s Phone:_______________________

Do you require a referral from your Primary MD? Y N

Do you require a referral from your Primary MD for eye care service? Y N

Note Your major medical insurance may pay for certain eye health related services.

ASSIGNMENT OF BENEFITS

I assign and authorize benefit payments from my insurance company to the eye care provider who rendered services. I further authorize this provider to release to my insurance company and its agents any information related to this or any related claim.

Signature of Patient / Guardian Date

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

Your insurance policy is a contract between you and your carrier. Many insurance policies cover eye exams, including services and materials. Your insurance company may determine the care or materials that are recommended and/or received are ***not*** a covered benefit. Please read your insurance handbook and be aware of what your insurance offers for benefits. When in doubt contact your insurance company directly for clarification.

I hereby assume full financial responsibility for (regardless of my insurance status) the full payment on my and/or my dependant's accounts for co-pays, deductibles, co-insurance and balance on fees charged for professional services and materials received.

Signature of Responsible Party Date

CONTACT LENS FEES

We are always concerned with the health and safety of you and your eyes. Contact lenses are a good solution for many patients, but the process takes additional time and commitment on your part and ours. Contact lens services are not included in the comprehensive or routine exam fees and additional service charges will apply. Fees will be dependent on the level of service necessary to provide you with the proper lenses for your situation. Contact lens materials are an additional fee.

REFRACTION FEE

The part of an eye examination that determines your prescription is the refraction. Refractions are also done under certain circumstances for diagnostic purposes. MEDICARE OR OTHER MEDICAL INSURANCES DO NOT COVER REFRACTIONS. The refraction is covered if you have vision insurance. The fee for the refraction is $40.00 and is collected at the time of service.

MEDICAL HISTORY QUESTIONNAIRE

MEDICAL HISTORY

List any allergies to medications:____

List any medications you take (include over the counter and home remedies):____

____

List all major injuries, surgeries and/or hospitalizations you have had:____

____

Females: Are you pregnant and/or nursing: □ no □ yes

Circle any of the following you have had: CROSSED EYES, LAZY EYE, GLAUCOMA, RETINAL DISEASE, CATARACTS, EYE INFECTION, EYE INJURY, OTHER:________________________

REVIEW OF SYSTEMS AND FAMILY HISTORY

Do you or have you (*INCLUDING ANY FAMILY MEMBERS*) had any problems in the following areas? If yes, *PLEASE DESCRIBE AND INDICATE WHO.*

CONSTITUTIONAL (Fever, Weight Loss / Gain)	Y	N
INTEGUMENTARY (Skin)	Y	N
NEUROLOGICAL	Y	N
EYES	Y	N
ENDOCRINE (Thyroid, other glands)	Y	N
EAR, NOSE, THROAT, MOUTH	Y	N
RESPIRATORY	Y	N
VASCULAR / CARDIOVASCULAR (Diabetes, Blood Pressure)	Y	N
GASTROINTESTINAL	Y	N
GENITOURINARY (Genitals, Kidney, Bladder)	Y	N
BONES / JOINTS / MUSCLES	Y	N
LYMPHATIC / HEMATOLOGIC	Y	N
ALLERGIC / IMMUNOLOGIC	Y	N
PSYCHIATRIC	Y	N
OTHER	Y	N

SOCIAL HISTORY

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

Do you use tobacco products	Y	N	type / amount / how long:________________________
Do you drink alcohol?	Y	N	type / amount / how long:________________________
Do you use illegal drugs?	Y	N	type / amount / how long:________________________

VISUAL / OCULAR INFORMATION

1. Have you ever worn contact lenses? Y N
2. If you have stopped wearing contact lenses, what is the reason for discontinuing wear?________________________

____

3. Do you experience burning, stinging eyes? Y N
4. Do you have trouble driving at night? Y N
5. Do you experience problems with glare? Y N
6. Do you work at the computer? Y N

____

Doctor's Signature Date