

# Vision First Eye Care Specialists

L. Page Pond, O.D. - Stacey K. Spaulding, O.D. - Ryan T. Reid, O.D.

## PATIENT INFORMATION:

LAST NAME		FIRST NAME	NICKNAME
MAILING ADDRESS		CITY & STATE	ZIP
PHONE #1: (BEST # TO CALL)	IS THIS? Cell Work Home Other	DATE OF BIRTH	AGE
PHONE #2:	IS THIS? Cell Work Home Other	EMAIL	
PHONE #3:	IS THIS? Cell Work Home Other	(LIKE US ON FACEBOOK TO RECEIVE OUR FEEDS FOR IN-OFFICE EVENTS AND SPECIALS @ tinyurl.com/vfes01) Visit our website @ pondyecare.com	
**Would you like to receive helpful text messages from us in the future to give you important reminders? <b>YES NO</b>		EMPLOYER:	
<b>DO YOU CURRENTLY WEAR? Glasses Contacts Neither</b>		OCCUPATION:	
Has anyone in your family been seen in our office before? Who?		PRIMARY CARE PHYSICIAN:	
How did you hear about us?		PHONE:	
		SPOUSE:	

## INSURANCE:

## POLICY HOLDER'S INFORMATION:

VISION INS.	MEMBER ID	FIRST & LAST NAME	DATE OF BIRTH
MEDICAL INS.	MEMBER ID	LAST FOUR OF SSN	YOUR RELATIONSHIP TO POLICY HOLDER
<b>- PLEASE PRESENT ALL MEDICAL/VISION INSURANCE CARDS TO RECEPTIONIST -</b>			

### VISION SAFETY NOTICE FOR OPTICAL LENSES

Of all materials from which lenses can be made, polycarbonate is the most impact resistant. Your plastic or glass lenses will meet or exceed American National Standard Z.08 and FDA requirement 21 CFR Sec. 801.410 for impact resistance, but they are not unbreakable or shatterproof. I understand that polycarbonate lenses are the most impact resistant, and others will not resist breakage to the same degree.

### NOTICE OF PRIVACY PRACTICES

I am aware that the office's Notice of Privacy Practices (HIPAA) is available to me via the office website or by submitting a request to the staff.

### FINANCIAL AGREEMENT

Insurance is a contract between you and a third party to reimburse for covered medical expenses. We cannot guarantee insurance company payments if you have not met eligibility or deductibles. Insurance is not a substitute for payment. If you subscribe to an HMO or PPO plan, please make your co-payment before you leave our office. Read your HMO/PPO book carefully as they will penalize you for not following their rules by non-payment for benefits which would result in our office billing you for the services that they would normally have covered.

All attorney fees and collection agency fees will be charged back to any patient with an outstanding debt over 90 days.

### CANCELLATION POLICY

There will be a \$65.00 fee for any appointment cancelled less than 48 hours in advance. By scheduling your appointment and signing this form, you agree to this policy.

**I have read and thoroughly understand this agreement.**

PATIENT SIGNATURE (OR PARENT/GUARDIAN IF A MINOR)

DATE

# MEDICAL HISTORY FORM

## EYE HISTORY:

Have you had any of the following?

- Cataracts
- Amblyopia (Lazy Eye)
- Refractive Surgery (Lasik, PRK)
- Glaucoma
- Retinal Detachment
- Loss of Vision
- Double Vision
- Dry Eyes
- Watery Eyes
- Floaters
- Iritis, Retinopathy, Neuropathy (MS)
- Macular Degeneration
- Infections

Are you using any eye drops?  Yes  No

If so, please list: \_\_\_\_\_

If you wear contacts, what type are they?

- Soft  Bifocal  Rigid
- Toric  Mono  Other

Have you had vision therapy or eye surgery?  Yes  No

If so, please describe: \_\_\_\_\_

Date of Last Eye Exam: \_\_\_\_\_

## GENERAL HEALTH CONDITIONS:

Do you currently have or have you ever had any of the following?

- NEUROLOGICAL (headaches, multiple sclerosis, migraines, seizures)
- CARDIOVASCULAR (stroke, heart disease, hypertension, cholesterol, other)
- CONSTITUTIONAL (fever, trauma, fatigue, weight gain/loss)
- EARS, NOSE, THROAT (sinus, upper respiratory infection)
- PSYCHIATRIC (depression, anxiety, bipolar, other)
- HEMOLOGIC (anemia, blood loss, other)
- IMMUNOLOGY (cancer, hepatitis, arthritis, allergies)
- ENDOCRINE (thyroid, diabetes, other glands)
- SKIN (cancer, rosacea, eczema, other)
- RESPIRATORY (asthma, COPD, emphysema, other)
- MUSCULOSKELETAL (fibromyalgia, osteoporosis, other)
- GENITO URINARY (viral, herpetic, chlamydia, other)

Describe any of the above conditions: \_\_\_\_\_

\_\_\_\_\_

List medications: \_\_\_\_\_

List Surgeries: \_\_\_\_\_

## SOCIAL HISTORY:

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

Yes, I prefer to discuss my Social History directly with the doctor.

Do you drive?  Yes  No

Do you use tobacco?  Yes  No

Do you drink alcohol?  Yes  No

Do you use recreational drugs?  Yes  No

Have you ever contracted any sexually transmitted disease?  Yes  No (chlamydia, gonorrhea, herpes)

Are you pregnant?  Yes  No

Are you breast feeding?  Yes  No

Hobbies/Sports: \_\_\_\_\_

FAMILY HISTORY - List any of the conditions in the General Health section that your family has a history of:

\_\_\_\_\_

\_\_\_\_\_

----- TO BE FILLED OUT BY STAFF -----

tech initials \_\_\_\_\_

Date: \_\_\_\_\_

Dr. Signature: \_\_\_\_\_

tech initials \_\_\_\_\_

Review Date: \_\_\_\_\_

Dr. Initial: \_\_\_\_\_

tech initials \_\_\_\_\_

Review Date: \_\_\_\_\_

Dr. Initial: \_\_\_\_\_

tech initials \_\_\_\_\_

Review Date: \_\_\_\_\_

Dr. Initial: \_\_\_\_\_