Vision First Eye Care Specialists

Dr. L. Page Pond, O.D.

Date: _____

PATIENT INFORMATION:

_____ _____ _____ _____

LAST NAME | FIRST NAME | MIDDLE INITIAL | NICKNAME

_____ _____ _____

MAILING ADDRESS | CITY & STATE | ZIP

PHONE #1:
(BEST # TO CALL) _____ _____

IS THIS? Cell Work Home Other | DATE OF BIRTH

PHONE # 2: _____ _____

IS THIS? Cell Work Home Other | EMAIL

PHONE #3: _____

IS THIS? Cell Work Home Other

VISIT OUR WEBSITE

Like us on facebook

** Would you like to receive helpful text messages from us in the future to give you important reminders? **Yes** **No**

EMPLOYER: _____

OCCUPATION: _____

DO YOU CURRENTLY WEAR? **Glasses** **Contacts** **Neither**

PRIMARY CARE PHYSICIAN (PCP): _____

Has anyone in your family been seen in our office before? Who? _____

PCP PHONE: _____

How did you hear about us? _____

Your spouses's name: _____

INSURANCE:

_____ _____

VISION INS. | MEMBER ID

_____ _____

MEDICAL INS. | MEMBER ID

POLICY HOLDER'S INFORMATION:

_____ _____

FIRST & LAST NAME OF POLICY HOLDER | THEIR DOB

_____ _____

LAST 4 OF THEIR SSN | YOUR RELATIONSHIP TO POLICY HOLDER

- PLEASE PRESENT ALL MEDICAL/VISION INSURANCE CARDS TO RECEPTIONIST -

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

- PLEASE FILL OUT BACK SIDE AS WELL -

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
- □ Chronic Infections

Are you using any eye drops? □ Yes □ No
If so, please list: _____
_____
_____

If you are new to our office and wear contacts, what type are they?
□ Soft □ Bifocal □ Rigid □ Other
□ Toric □ Mono □ Unsure

Have you had vision therapy or eye surgery? □ Yes □ No
If so, please describe: _____
_____

Date of last eye exam (if seen elsewhere): _____
Doctor's Name (if seen elsewhere): _____

GENERAL HEALTH CONDITIONS:
Do you currently have or have you ever had any of the following?

- □ NEUROLOGICAL (chronic headaches, multiple sclerosis, migraines, seizures)
- □ CARDIOVASCULAR (stroke, heart disease, hypertension, high cholesterol, other)
- □ CONSITUTIONAL (chronic fever, trauma, fatigue, substantial weight gain/loss)
- □ EARS, NOSE, THROAT (sinus, upper respiratory infection)
- □ PYSCHIATRIC (depression, anxiety, bipolar, other)
- □ HEMOLOGIC (anemia, blood loss, other)
- □ IMMUNOLOGY (HIV, 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 (STD, viral, herpetic, chlamydia, other)

Describe any of the above conditions: _____
_____
_____
_____

Do you take any prescription or over the counter medications? □ Yes □ No
If so, please list (excluding dosages): _____
_____
_____

Are you allergic to any medications? □ Yes □ No
If so, please list: _____
_____

List surgeries: _____

FAMILY HISTORY – List any of the conditions in the GENERAL HEALTH section that your family has a history of:_____
_____
_____

SOCIAL HISTORY:
This information is strictly confidential, you may discuss this portion directly with the doctor if you prefer.
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
Are you pregnant? □ Yes □ No
Are you breast feeding? □ Yes □ No
Hobbies/Sports: _____
Approximate hours of daily computer use: _____

-------- 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: _____