First Name: _____Last Name: _____Middle Initial: ___ Preferred Name: _____

Birth Date: _____ Social Security Number: _____ Sex: **M / F**

Address:_____ City:_____ State: _____ Zip:_____

Phone Number: Home _____Work _____ Cell _____ Email_____

Employer: _____

Marital status: **Single Married Widowed**

Preferred Language_____ Race/Ethnicity_____

Policy Holder:_____ Subscriber Social Security Number:_____

Subscriber's Birth Date:_____ Subscriber's Employer: _____

Primary Medical Insurance/Policy Number: _____ Secondary Medical Insurance/Policy Number:_____

Vision Insurance:/PolicyNumber_____

What are your visual symptoms today? Please check any that apply:

___Blurry Vision ___ Burning ___Floaters/Spots ___Haloes ___Double Vision ___ Itching ___Flashes of Light ___Eye Strain ___Dry Eyes

___Headaches ___Eye Infection ___Redness ___Loss of Vision ___Eye Pain ___Watering/Discharge ___Crossed Eye

Date of Last Eye Exam:_____/___/_____ Eye Doctor's Name:_____

Do you wear glasses? Yes / No How old are your present glasses? _____ years Do you wear prescription Sun Wear? Yes/No

Are you interested in contacts? Yes / No Do you wear contacts? Yes / No

Brand/Powers: Right Eye_____Left Eye_____

Contact Lens Solution:_____

Replacement Schedule: **Daily / 2 week / Monthly / Yearly** Wearing Schedule: **Daily / Overnight**

Have you ever had an eye injury or surgery? Yes / No Type_____ Which Eye?_____ When?_____

Do you use eye medication? Yes /No Name of Medication (s):_____

PERSONAL MEDICAL HISTORY : PLEASE CHECK ANY OF THE FOLLOWING THAT APPLIES TO **YOU**

Cardiovascular ____High Blood Pressure ___High Cholesterol ___Stroke ___Heart Disease

Endocrine ___Type I Diabetes ___Type 2 Diabetes ___Thyroid Disease ____Hormonal Dysfunction ___Other

Respiratory ___Respiratory ___Asthma ___Bronchitis ____COPD ___Emphysema ___Other

Psychiatric ____Memory Loss/Confusion ___Depression ___Anxiety ___Mental Illness ___ADHD ___Other

Eyes ___Glaucoma ___Keratoconus ___Macular Degeneration ___Retinal Detachment ___Cataracts ___Retinal Disorder ____Other

Constitutional ___Weight Gain ___Fever ___Fatigue __Cancer

Neurological ___Migraine Headaches ___Seizures ___Stroke ___Alzheimer's ___Other

Musculoskeletal ___Osteoarthritis ___Rheumatoid Arthritis ___Fibromyalgia ___Multiple Sclerosis __Other

Dermatologic ___Eczema __Rosacea ___Psoriasis ___Hives ___Other

Immunologic ___AIDS/HIV ___Lupus ___Neurofibromatosis ___Other

Hematologic/Lymphatic ___Sickle Cell Anemia ___Hepatits ___Past Transfusion ____Other

Gastrointestinal ___Nausea/Vomiting ___Crohn's Disease ___Colitis ___Other

Ear/Nose/Throat ___Hearing Loss/Ringing ___Upper Respiratory Infection ___Chronic Sinus/Rhinitis

Current Medications:_____

Drug Allergies:_____

Alcohol Use: Y N Amount:_____ **Tobacco Use: Y N** Amount: _____

FAMILY HISTORY: Has anyone in your family (Parents or Siblings) been diagonsed with:
_____Retinal Detachment _____Blindness _____Cataracts _____Glaucoma _____Crossed Eyes _____Macular Degeneration _____Other Eye Disease
_____Diabetes ___High Blood Pressure ____Cancer ___Heart Disease ____High Cholesterol

HOW DID YOU HEAR ABOUT US?
_____Friend/Relative _____Doctor_____ Insurance List _____SignBuilding _____Website _____ Other (Referred By)_____

NOTICE OF PRIVACY PRACTICES: I have been shown and offered a copy of Reflections Vision Center statement of privacy policies.
SIGNATURE (Parent Signature if Minor**):** _____ **DATE:**_____

INSURANCE I, the undersigned, authorize payment of medical benefits to this physician, for any services furnished to me by the physician, I understand I am financially responsible for any amount not covered by my insurance policy. I also authorize Reflections Vision Center to release information to my insurance company concerning healthcare, advice, treatment or supplies provided to med. This information will be used for the purpose of evaluating and administering claims and benefits.
LIFETIME SIGNATURE:_____ **DATE:**_____

MEDICARE I, the undersigned, understand that this clinic accepts assignment of Medicare. I agree to be responsible for my deductible and/or any uncovered charges as well as 20% of the allowance of covered services. I request that payment of authorized Medicare benefits be made on my behalf to this physician for any services furnished to me by this physician. I authorize any holder of medical information about me to be released to the Healthcare Financing Administration and its agents to determine benefits or benefits payable for related services.
LIFETIME SIGNATURE:_____ **DATE:**_____

MEDICAID I agree to be responsible for any services not covered by Medicaid. I request that payment of authorized Medicaid benefits be made on my behalf to this physician. I authorize any holder of medical or other information about me to be released to the Division of Medicaid or its Fiscal Agent or any information needed to determine these benefits payable for related services.
LIFETIME SIGNATURE:_____ **DATE:**_____

OFFICE POLICY ON PAYMENT: I understand that I am responsible for payment of all charges. As a courtesy, if applicable, my insurance will be billed for me. It is my responsibility to pay any deductible, co pay, or any remaining balance not paid by my insurance company. I authorize insurance benefits to be paid directly to the provider. I understand that I am responsible for my deductible and any portion not covered by my insurance at the time services are rendered. I further agree that should the account become delinquent and require collection efforts, I agree to pay the cost of collections, including reasonable attorney's fees and collection agency fees. I also understand there is a $40.00 fee for any returned checks for insufficient funds.

VISION PLAN COVERAGE: I understand that only one vision plan may be used for exam/materials per visit-per patient and that the vision plan to be used must be chosen before the exam occurs and cannot change at a later date:

_____ _____
PRINTED NAME OF PATIENT OR REPRESENTATIVE DATE

_____ _____
SIGNATURE RELATIONSHIP TO PATIENT