First Name: ___________________________ Last Name: _________________________ Middle Initial: ____ Preferred Name: _________________

Date of Birth: ___________________ 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: _________________________

Insurance

Policy Holder: ____________________________________ Subscriber Social Security Number: ______-______-________

Subscriber's Date of Birth: ____________________ Subscriber's Employer: ____

Primary Medical Insurance/Policy Number: ____

Secondary Medical Insurance/Policy Number: ____

Vision Insurance/Policy Number: ____

What are your visual symptoms today? Please check all 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 If so, how old are your current glasses? _____________ 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 II 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
- ☐ Hepatitis
- ☐ 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 diagnosed with:

- ☐ Retinal Detachment
- ☐ Blindness
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Crossed Eyes
- ☐ Macular Degeneration
- ☐ Other Eye Diseases
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Cancer
- ☐ Heart Disease
- ☐ High Cholesterol

HOW DID YOU HEAR ABOUT US?

_____Friend/Relative _____Doctor _____Insurance List _____Sign/Building _____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/Guardian 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 me. 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 charge 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 collections 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