

Thank you for choosing our practice for your eye care needs. **PLEASE COMPLETE THIS FORM IN BLACK OR BLUE INK.** If you have any concerns, do not hesitate to ask for assistance. We will be happy to help.

Name: Last \_\_\_\_\_ First \_\_\_\_\_ M.I.

\_\_\_\_\_ Preferred Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_ Work

Phone: \_\_\_\_\_ Ext. \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age

\_\_\_\_\_ Male / Female SS#: \_\_\_\_\_

Marital Status  Single  Married  Other E-Mail Address:

\_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

How were you referred to our office?

Friend or Family Member: \_\_\_\_\_  Insurance Company  Internet

Family Doctor: \_\_\_\_\_  Ophthalmologist:

**Please list all insurances, vision and medical. Please bring all insurance cards with you to your appointment.**

**All information needs to be completed in addition to providing a copy of your cards.**

Ins. Co. Name:	Ins. Co. Name:
Address:	Address:
Insured's Name:	Insured's Name:
Identification Number:	Identification Number:
Group #:	Group #:
Insured's D.O.B.:	Insured's D.O.B.:
Insured's SS#:	Insured's SS#:
Patient Relation to Insured:	Patient Relation to Insured:

### **EYEGLOSS HISTORY**

Do you wear glasses?  Yes  No  Full Time  Part Time  Distance  
 Near

Glasses Owned:  Single Vision  Bifocals  Safety Glasses

Back up Glasses  Progressive  Trifocals  Sports Glasses

Other

Computer Used:  Yes  No Hours per Day: \_\_\_\_\_ Distance from  
Computer: \_\_\_\_\_

Do you have problems with glare?

Yes  No

Do you have problems with night vision?

Yes  No

Are you allergic to Nickel (e.g.: jewelry or eyeglass frames discoloring your skin)?

Yes  No

If you currently wear eyeglasses, are there certain times when you would rather not?

Yes  No

(e.g. sports, business presentations, social occasions etc.)

If you currently wear eyeglasses, does your spare pair have your correct prescription?

Yes  No

Do your sunglasses have UV (ultra-violet) protection?

Yes  No

Are your sunglasses your current prescription?

Yes  No

### **CONTACT LENS HISTORY**

Do you currently wear contact lenses?  Yes  No

Have you ever tried to wear contact lenses?  Yes  No Reason for stopping:

\_\_\_\_\_

Are you interested in changing your eye color?  Yes  No

If you currently wear contact lenses, do your backup eyeglasses have your correct prescription?  Yes  No

Answer the questions below only if you currently wear contact lenses:

What type or brand of contacts do you wear? \_\_\_\_\_

How old are your current lenses? \_\_\_\_\_

How often do you replace or dispose of your contact lenses?

\_\_\_\_\_ What brand of solution do your lenses soak in overnight? \_\_\_\_\_

What is your typical wearing schedule? \_\_\_\_\_ Hours/day \_\_\_\_\_ Days/Week

Are you having any problems with your current contact lenses?  Yes  No

Would you like to be evaluated for refractive laser surgery?  Yes  No

No

Would you like to be evaluated for a NON-surgical method to correct your vision?  Yes  No

No

Date of last Eye Exam: \_\_\_\_\_ Where did you get your last exam?

\_\_\_\_\_ Phone: \_\_\_\_\_ Address: \_\_\_\_\_

Date of last Physical Exam: \_\_\_\_\_ Name of Primary Care Physician (PCP): \_\_\_\_\_

PCP Phone: \_\_\_\_\_ Address: \_\_\_\_\_

\_\_\_\_\_

**Why did you schedule your appointment today?**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### **Medical History**

**EYE HISTORY:** With vision correction being used, do you suffer from any of the

following?

Distance vision blur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seeing Flashes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dry Eyes
	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Near Vision Blur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Distorted Vision (haloes)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Itching
	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Middle dist. Vision blur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glare/ Light sensitivity	<input type="checkbox"/> Yes <input type="checkbox"/> No	Red eyes
	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Double Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	Loss of side vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	Eye pain/
soreness	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Crossed Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mucous
Discharge	<input type="checkbox"/> Yes <input type="checkbox"/> No			

**REVIEW OF SYSTEMS:** Many diseases of the body have grave eye health consequences. Please answer the following questions. While they may seem unrelated to an eye problem, it is crucial to your care that we ask them.

Do you currently have any of the following problems? Yes      No      If YES,  
 please explain:

Chronic fever, unexpected weight loss/gain fatigue	<input type="checkbox"/>	<input type="checkbox"/>	
_____			
Ear/nose/throat problems (e.g. Hearing loss, sinus problems, sore throat)	<input type="checkbox"/>	<input type="checkbox"/>	
_____			
Heart problems (e.g. Chest pain, irregular heart beat, swelling of feet, cold hands or feet)	<input type="checkbox"/>	<input type="checkbox"/>	
_____			
Respiratory problems (e.g. Shortness of breath, wheezing, coughing)	<input type="checkbox"/>	<input type="checkbox"/>	
_____			
Gastrointestinal problems (e.g. Heartburn, abdominal pain, diarrhea, vomiting)	<input type="checkbox"/>	<input type="checkbox"/>	
_____			
Genitourinary problems (e.g. Painful urination, blood in urine, sex organ problems)	<input type="checkbox"/>	<input type="checkbox"/>	
_____			
Musculoskeletal problems (e.g. Muscle aches, joint pain, swollen joints)	<input type="checkbox"/>	<input type="checkbox"/>	
_____			
Skin problems (e.g. Rashes, excessive dryness, growths or lumps)	<input type="checkbox"/>	<input type="checkbox"/>	
_____			
Neurological problems (e.g. Numbness, weakness, headaches, "blackouts")	<input type="checkbox"/>	<input type="checkbox"/>	
_____			
Psychiatric problems (e.g. Depression, anxiety)	<input type="checkbox"/>	<input type="checkbox"/>	
_____			
Endocrine problems (e.g. Frequent urination, thirst, feeling hot or cold all the time)	<input type="checkbox"/>	<input type="checkbox"/>	
_____			
Blood/lymph problems (e.g. Bruising, weakness, unusual paleness, swollen glands)	<input type="checkbox"/>	<input type="checkbox"/>	
_____			
Immune problems (e.g. Frequent infections, allergic reactions to foods, dust, pollens)	<input type="checkbox"/>	<input type="checkbox"/>	
_____			

Have you ever been treated for any medical conditions? (e.g. Diabetes, high blood pressure, arthritis, etc.)?

Yes  No

If YES, please explain:

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Have you ever had any eye disease? (E.g. Glaucoma, cataract, wandering or "lazy" eye, retinal detachment)?

Yes  No

If YES, please explain:

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Have you ever had any surgery or been hospitalized?

Yes  No

If YES, please provide date and reason

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Do you take any medications?

Yes  No  
If YES, please list

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Do you have any food or drug allergies?

Yes  No  
If YES, please list:

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**FAMILY HISTORY:**

Do any MEDICAL or EYE diseases run in your family (BLOOD relatives) (e.g. Diabetes, high blood pressure, cancer, glaucoma, macular degeneration, etc.)?

Yes  No  
If YES, please specify:

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**SOCIAL HISTORY:**

Do you drink alcohol?	<input type="checkbox"/> No	<input type="checkbox"/> Occasionally	<input type="checkbox"/> 1/day	<input type="checkbox"/> 2-3/day
<input type="checkbox"/> 4+/day				
Do you smoke?	<input type="checkbox"/> NO	<input type="checkbox"/> Occasionally	<input type="checkbox"/> ---cig/day	<input type="checkbox"/> 1 pack/day
<input type="checkbox"/> 1+ pack/day				

**It is the patient's responsibility to furnish Spartanburg Vision with any current insurance, address or referral information. The patient is responsible for all fees, regardless of insurance coverage. You are required to pay all co-payments/ co-insurance at the time of the service. If determination of benefits cannot be obtained at the time of the visit, you are expected to pay for services rendered, and we will reimburse you when your insurance remits payment to our office.**

**If eyewear or contact lenses are ordered, a deposit of at least 50% is required. It is customary to pay for services when rendered unless other arrangements have been made in advance. We accept cash, check, Master Card, Visa, Discover and American Express**

**MEDICARE INSURANCE INFORMATION**

We accept Medicare assignments, which means we file office visits for you. You are responsible for your \$100 deductible each year, as well as the 20% that Medicare does not pay. You are also responsible for claims that are not covered by Medicare

**MEDICAID INSURANCE INFORMATION**

We accept Medicaid assignments, which means we file office visits for you. Medicaid provides eye exams to all participants. If you would like a contact lens evaluation there is an additional charge. Glasses are provided to patients who have not yet reached their 21<sup>st</sup> birthday. Contact lenses are not covered. You are responsible for claims that are not covered by Medicaid. **We must have a copy of your Medicaid card on file.**

**Authorization**

I certify that I have read and understand the above information to the best of my knowledge.

The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the eye doctor to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such eye care to third party payers and/or health practioners. I authorize and request my insurance company to pay directly to the eye doctor or ophthalmic group insurance benefits otherwise payable to me. I understand that my eye care insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or of my dependents.

**X**

\_\_\_\_\_  
Signature of Patient (or guardian if a minor) Date

**Notice of Privacy Practices**

**Spartanburg Vision is concerned about the privacy of our patient’s health care information. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your health care service will in no way be conditioned upon your signed acknowledgment. If you decline to provide a signed acknowledgment, we will continue to provide your treatment and will use your protected health information for treatment, payment and health care operations when necessary.**

**We have copies of this notice on file. If you would like to read a copy or have a copy for your records, please ask a member of our staff.**

**Please list who we may discuss your eye care with:**

\_\_\_\_\_

\_\_\_\_\_  
**Patient Name (print)**

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\_\_\_\_\_  
**Signature of Patient or Authorized Representative Date**

**Spartanburg Vision**  
**Tom Macmillan, OD    Jeremy Anderson, OD    Leann Geerts, OD**