PATIENT INFORMATION

Thank you for choosing our practice for your eye care needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

Name _____ Date _____
First MI Last

Address_____ City_____ State_____ Zip_____

Birthdate _____ Main Phone_____ Work Phone _____

E-Mail Address _____ Sex: M F

How would you like us to contact you? Text Email Cell Work

Preferred Language_____ If Spanish, Do you need an interpreter?_____

Your/parent's employer _____ Occupation _____

Responsible party_____ Contact #_____

Mailing Address _____

Emergency Contact _____ Phone _____

PRIVACY PRACTICE ACKNOWLEDGEMENT

Due to new Privacy Practices, Vision Concepts will not release your information to anyone unless you give us permission. Please list anyone that you would like to have access to your information, this includes picking up contact lenses or glasses .

_____

I have received the Notice of Privacy or I have been provided an opportunity to review it.

Signature _____ **Date** _____

HEALTH HISTORY

Reason for today's exam _____

Date of last eye exam_____ Name of eye doctor _____

Primary Care Physician_____ Name of Clinic _____

Do you or anyone in your immediate Family have a history of the following?

Self Family: Please specify who in family

Diabetes _____
High blood pressure _____
Thyroid disease _____
Heart condition _____
Crossed/ Lazy Eye _____
Blindness _____
Glaucoma _____
Cataract _____
Other _____

Medications you are currently taking: (or Pharmacy name)

_____
_____
_____
_____
_____
_____
_____

Drug allergies: _____
_____

Please check any of the following conditions that apply to you:

Frequent headaches Pregnant/ Breastfeeding Have given birth in the last 6 months
Allergies/ sinus trouble

Have you ever had any of the following conditions involving your eyes?

Eye surgery Eye infection or disease Double vision
Eye injury Floaters or spots Eyes burn, itch, or water

Do you wear contacts? Yes No If no, are you interested? Yes No

When do you wear your glasses?

All the time Reading/Computer Distance only Other:_____

Tobacco use: Never Smoker Current smoker Former smoker

If you are a smoker:

- How many packs per day? less than 1 pk/day more than one pk/day
- How many years have you been smoking? _____

Alcohol use: None Social 1 - 2 Drinks per day More than 3 drinks per day

Recreational drug use: None Recreational Chemical Dependence
STD diagnosis: None Yes HIV Positive

DIABETICS ONLY: when was the last time you checked your sugar? _____ Results _____

When was your last A1C test? _____ Results_____

PATIENT FINANCIAL POLICY STATEMENT

Dr. Joshua McCown and the staff at Vision Concepts are here to serve your visual needs as our patient. It is our goal to create a pleasant experience for our patients and avoid misunderstandings regarding financial responsibilities.

OUR RESPONSIBILITY is to assist you in understanding the provisions and limits of your insurance company and to accurately file claims in a timely manner. We will verify benefits but cannot guarantee that your insurance will pay as quoted.

YOUR RESPONSIBILITY is to be knowledgeable regarding your benefits, co-pays, and deductible and co-insurance amounts. It is ultimately the patient's responsibility for the payment of services that will/have been provided even if your insurance denies the claim or does not pay as expected. _____ **Initial here**

I understand that it is my responsibility to call my insurance company if I have any questions regarding my benefits. _____ **Initial here**

It is my responsibility to provide my insurance card and verify my address and phone number at each visit. If your insurance changes, please notify us immediately, because all insurance companies have a time limit to file claims. _____ **Initial here**

I agree that I will be expected to pay my co-pay, co-insurance or any payments that are not covered by my insurance, prior to picking up your contacts or glasses. _____ **Initial here**

Your signature below indicates that you have read, understood and agree to the policy. A copy is provided upon request.

_____ _____

Patient/Guarantor Signature Date