NORTHWEST VISION CENTER

Please fill out the following patient information sheet so we may best serve you.

Date___________________________

PATIENT INFORMATION

( ) Mr. ( ) Miss ( ) Mrs. ( ) Ms. ( ) Dr. ( ) Rev.

Last Name____ First Name____ MI___________

DOB_________________________ SSN ____________________________________ Occupation____

Address____ City__________________________ State______________ Zip____________________

Home Phone #________________________________ Work Phone #______________________________ Mobile Phone #____________________________

How do you prefer we contact you? ( ) Home Ph# ( ) Work Ph# ( ) Mobile Ph# ( ) E-Mail ____

When was your last eye exam (if not here) _______________ Were your eyes dilated? ( ) Yes ( ) No Previous Eye Doctor__________________________

Have you ever worn glasses? ( ) Yes ( ) No Do you currently wear glasses? ( ) Yes ( ) No If yes: ( ) full time ( ) part time

Have you ever worn contact lenses? ( ) Yes ( ) No Do you currently wear contact lenses? ( ) Yes ( ) No What kind/brand?____________________

Have you had problems wearing contacts? ( ) Yes ( ) No Describe____

Are you interested in trying contacts? ( ) Yes ( ) No Are you interested in laser vision correction? ( ) Yes ( ) No

Please tell us the reason for your visit today? ____

PATIENT HEALTH HISTORY: Please check the conditions that apply to you or a blood relative and list the relative with the condition.

Condition	Self	Relative	Condition	Self	Relative
High Blood Pressure	( ) Self	( ) Relative____________________	Lazy Eye	( ) Self	( ) Relative____________________
Diabetes	( ) Self	( ) Relative____________________	Turned Eye	( ) Self	( ) Relative____________________
Elevated Cholesterol	( ) Self	( ) Relative____________________	Color "Blind"	( ) Self	( ) Relative____________________
Heart Problem	( ) Self	( ) Relative____________________	Blindness	( ) Self	( ) Relative____________________
Respiratory Disease	( ) Self	( ) Relative____________________	Retinal Detachment	( ) Self	( ) Relative____________________
Cancer	( ) Self	( ) Relative____________________	Cataracts	( ) Self	( ) Relative____________________
Thyroid Disease	( ) Self	( ) Relative____________________	Glaucoma	( ) Self	( ) Relative____________________
Migraines or Headaches	( ) Self	( ) Relative____________________	Macular Degeneration	( ) Self	( ) Relative____________________
Pregnant	( ) Self		Eye Strain	( ) Self	
Head Trauma	( ) Self		Dry Eyes	( ) Self	
Seasonal Allergies	( ) Self		Floaters/Spots	( ) Self	
Drug Allergies	( ) Self		Flashing Lights	( ) Self	

List Your Drug Allergies____ Eye Surgery or Injury____

Other Medical/Eye Problems or Issues____

Do you use: Cigarettes/tobacco? ( ) Yes ( ) No Alcohol? ( ) Yes ( ) No Other substances? ( ) Yes ( ) No

Are you currently under a physician's care? ( ) Yes ( ) No Doctor's name_________________________________ Date of last physical_______________

Current medications____ How is your health? ( ) Excellent ( ) Good ( ) Fair ( ) Poor

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Insurance that covers today's visit? ( ) None ( ) VSP ( ) PVCS ( ) BCBS ( ) Aetna ( ) Soonercare ( ) Other____________________________

( ) Medicare (Medicare will not cover routine vision exams. There must be a medical reason for the visit.)

PRIMARY INSURED PERSON INFORMATION

( ) patient is primary insured

Last Name____ First Name____MI_______________

DOB___________________________________ SSN____

Address ( ) same as patient ____ City_______________________State____________Zip______________

NEW PATIENTS: WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE OR HOW DID YOU CHOOSE OUR OFFICE?

( ) Insurance List ( ) Another Doctor ( ) Yellow Pages ( ) Friend ( ) Relative ( ) Location ( ) Patient Referral ____________________ ( ) Other

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PAYMENT TERMS: Our office policy calls for payment or applicable co-pay at the time of service. If your insurance does not pay the anticipated amount, or your insurance pays you directly, you must pay the balance. If eyewear or contact lenses are to be ordered, a minimum 50% deposit is required and the balance is due upon delivery. We accept cash, personal checks, Visa and Mastercard. If paying by check, we will ask to make a copy of your driver's license. A monthly rebilling fee of $5 is added to all accounts with unpaid balances after 30 days. I also agree that my insurance company may obtain or review a copy of my records. I have read and agree to all the provisions of the office financial policy.

Signed____Date________________Driver's License # (only if paying by check)________________________

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I read the Notice of Privacy Policy listed on the following website:

nwvisioncenter.com

I understand that I may print out a copy for myself or pick up a copy at the front desk of Northwest Vision Center.

Please print the patient's name____

Signature ____