Welcome to Our Office

Patient and Responsible Party Information

First Name_____MI____Last Name_____(Jr, Sr, etc)_____Nickname_____

Address_____ Social Security #_____

City_____ Birthdate_____

State, Zip_____ Sex (circle) M F Marital Status (circle) S M D W

Home # _____ Work # _____ Cell # _____

Employer_____ Occupation_____

Email Address _____ Communication Preference (circle) Email Telephone Postal

Payment Information

We accept cash, Care Credit, and all major credit cards except American Express.

Payment Policy: Payment in full is expected at the time professional services are rendered and/or materials are ordered. We are happy to file for insurance payment when applicable. A charge of 1.5% per month will be added to all accounts 30 days past due. ***Initial***_____

Failure to pay balances in the allotted time will result in patient incurring additional costs of collection including, but not limited to attorney or legal fees, collection agency fees and finances charges. ***Initial***_____

Acknowledgment

If insurance is filed on my behalf, I authorize my insurance benefits to be paid directly to ClarityVision. ***Initial***_____

I agree that unless ClarityVision and my insurer have a prior agreement, I am personally responsible for all non-covered services, co-pays and deductibles. ***Initial***_____

I authorize the release of medical information to insurance carrier or other physicians if it is deemed necessary by my optometrist for financial or consultative purposes. ***Initial***_____

Responsible Party (Please Print)_____SSN#_____

Responsible Party (Signature)_____Date_____

AUTHORIZATION FOR RELEASE OF INFORMATION

ClarityVision is authorized to release protected health information, pertaining to the above named patient, in the methods below: (Initial)
_____ Leave information on voice mail _____ Give materials (contacts, glasses, prescriptions) to authorized person. Other:_____
AUTHORIZED RECIPIENTS:

_____ Relationship: _____

_____ Relationship: _____

DESCRIPTION OF INFORMATION TO BE RELEASED *(initial)*
_____ All Information _____Financial or billing information _____ Medical information including results from any test Other_____
RIGHTS OF THE PATIENT:I understand I have the right to revoke this authorization at any time by sending a written notification. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by state or federal law. I understand I have the right to inspect or copy the protected health information to be used or disclosed as described in this document, and that I may do this by written notification. I understand my treatment will not be conditioned on signing this authorization.

Signature of Patient or Personal Representative:_____ Date: _____

Print or Type Name of Patient or Personal Representative: _____

Description of Personal Representative's Authority (attach necessary documentation) _____

Medical History

Name_____ DOB:_____ ❑M ❑F Age:____ Race_____Date:_____

Last Eye Exam_____ Eye Doctor_____ Last Physical Exam_____ Medical Doctor_____

Mandatory Vitals for Electronic Records (self-reported estimate) Height:_____Weight:_____lbs

Describe your reason for visit. (Example: blurry vision, contact lenses, medical eye condition, etc…)

Glasses and Contact Lens History

Wear Glasses ❑YES ❑NO Do you experience glare or night vision problems? ❑YES ❑NO

Contact Lens ❑YES ❑NO Brand (if known)?_____ Would you like to try Contacts? ❑YES ❑NO

Do you sleep in your contacts? ❑YES ❑NO When do you throw them away?_____ What solution do you use?_____

Please list **ALL MEDICATIONS** (including eye drops): ❑No Medications

Do you have **ANY ALLERGIES TO MEDICATIONS**? ❑YES ❑NO **(IF YES, PLEASE LIST WITH EXPLANATION)**

Do you have **ANY EYE CONDITIONS**? **(IF YES, PLEASE LIST CHECK THE BOX THAT APPLIES AND EXPLAIN IN SPACE PROVIDED)**

❑Glaucoma ❑Cataracts ❑Macular Degeneration ❑Blindness ❑Lazy eye/Eye turn ❑Retinal detachment ❑Other, Please list:

Social History

Tobacco ❑YES ❑NO If YES, packs/day_____

Alcohol ❑YES ❑NO If YES, amount used_____

Drugs ❑YES ❑NO

Do you currently live alone? ❑YES ❑NO ❑Nursing home

Do you ***currently*** have any problems in the following areas? If YES, please provide an explanation.

MEDICAL AND OCULAR HISTORY	YES	NO	EXPLANATION OF PROBLEM (AND YEAR OF DIAGNOSIS)
EYES (Injuries or surgeries ONLY)			
ALLERGIC/IMMUNOLOGIC (lupus, sjogren's, etc.)			
CARDIOVASCULAR (heart, high blood pressure, etc.)			
GENERAL HEALTH (fever, weight loss, etc.)			
ENDOCRINE (diabetes, hypothyroid, etc.)			
GASTROINTESTINAL (stomach or intestines)			
GENITAL, KIDNEY, BLADDER			
EARS. NOSE, THROAT			
BLOOD, LYMPH (anemia, sickle cell, HIV, Hep, etc)			
SKIN (skin cancer, acne, rosacea, etc.)			
MUSCLES, BONES, JOINTS			
NEUROLOGICAL (multiple sclerosis, etc.)			
PSYCHIATRIC (anxiety, depression, etc.)			
RESPIRATORY (asthma, emphysema, etc.)			
PREGNANCY			**WEEKS:**

FAMILY MEDICAL AND OCULAR HISTORY:

YES	NO	CONDITION	RELATIONSHIP	YES	NO	CONDITION	RELATIONSHIP
❑	❑	Blindness	❑GP ❑Parent ❑Br/Sis	❑	❑	Arthritis	❑GP ❑Parent ❑Br/Sis
❑	❑	Eye Tumor	❑GP ❑Parent ❑Br/Sis	❑	❑	Cancer	❑GP ❑Parent ❑Br/Sis
❑	❑	Lazy/Turned Eye	❑GP ❑Parent ❑Br/Sis	❑	❑	Diabetes	❑GP ❑Parent ❑Br/Sis
❑	❑	Cataract	❑GP ❑Parent ❑Br/Sis	❑	❑	Heart Disease	❑GP ❑Parent ❑Br/Sis
❑	❑	Glaucoma	❑GP ❑Parent ❑Br/Sis	❑	❑	High Blood Pressure	❑GP ❑Parent ❑Br/Sis
❑	❑	Macular Degen.	❑GP ❑Parent ❑Br/Sis	❑	❑	Kidney Disease	❑GP ❑Parent ❑Br/Sis
❑	❑	Retinal Detachment	❑GP ❑Parent ❑Br/Sis	❑	❑	Thyroid Disease	❑GP ❑Parent ❑Br/Sis