Welcome to ABC Vision Source

Dr Mari Ward & Dr Wesley Crockett

PATIENT INFORMATION

Name ______________________________Today's Date ______________________

Reason for today's visit ____

Address ____________________City________________State________Zip_________

Phone: Home ________________Cell______________Work______________________

Other _____________________Email_______________________________________

*Birth Date*_______________________Age________________SSN__________________

M**_____*****F*****_____**Single_____Married_____ ***Preferred method of communication?* Email – Postal - Telephone***

Please Circle one of the following below for each Category*

Race: American Indian or Alaskan Native - Asian - Black or African American - Hispanic - Hawaiian/Pacific Islander - White

Ethnicity: Hispanic or Latino – Native Hawaiian or Pacific Islander – Not Hispanic or Latino

Preferred Language: English – Spanish – Other_______________

Employer______________________________ Occupation____________________

Are you required to wear safety glasses at work? ☐**YES** ☐**NO**

Who may we thank for your referral?____

PERSON RESPONSIBLE FOR BILLING (If same as above, check ☐)

Name____
Mailing Address__________________________City____________________State______Zip________
Phone: Home__________________________Cell_____________________Work________________
Other______________________________Email______________________________________
Birth Date_____________________________Age______________SSN______________________

INSURANCE INFORMATION

VISION INSURANCE______________________ID#____________________Group______________
Name of Insured__________________________________Birth Date__________________________
MEDICAL INSURANCE____________________ID#____________________Group______________
Name of Insured__________________________________Birth Date__________________________

PLEASE TURN THE PAGE OVER TO COMPLETE THE BACKSIDE, THANK YOU!

* All bold italicized information is required by the Health Information Technology for Economic and Clinical Health Act of 2009.

+VISION HISTORY

Do you ever experience Dry eyes? ☐**YES** ☐**NO** Do you utilize a computer? ☐**YES** ☐**NO**

Are you interested in vision correction surgery? ☐**YES** ☐**NO** Are you interested in Contact Lenses? ☐**YES** ☐**NO**

What indoor hobbies do you enjoy? ____

What outdoor hobbies do you enjoy? ____

If you could change one thing about your current lenses, what would it be? ______________________________

HEALTH HISTORY

Please list any medications you take and the reason for taking them______________________________________
____

Are you ALLERGIC to any medications? ____

Do you currently have any problems in the following areas? If "yes" please explain:

	YES	NO	
Eye Conditions (Glaucoma, diabetic retinopathy, macular degeneration, other)	☐	☐	________________
General Constitution (Fever, weight loss, other)	☐	☐	________________
Allergy/Immunologic (Hay fever, lupus)	☐	☐	________________
Blood / Lymph (High cholest. blood pressure, anemia)	☐	☐	________________
Cardiovascular (Blood vessel condition, heart disease)	☐	☐	________________
Ears, Nose, Throat (Cold, sinus, cough)	☐	☐	________________
Endocrine (Diabetes, thyroid)	☐	☐	________________
Gastrointestinal (Ulcers, intestinal disease)	☐	☐	________________
Genital / Urologic (Kidney disease, bladder)	☐	☐	________________
Neurological (Multiple sclerosis, seizures, stroke)	☐	☐	________________
Psychiatric (Anxiety, depression)	☐	☐	________________
Respiratory (Asthma, COPD, Emphysema)	☐	☐	________________
Skin (Rosacea, skin cancer)	☐	☐	________________

Does anyone in your **FAMILY** have a history of: ☐ **Diabetes** ☐ **Glaucoma** ☐ **Macular Degeneration**

Do you use any of the following: ☐ Alcohol ☐ Cigarettes ☐ Other Substances ☐ None

*****Information is required by the Health Information Technology for Economic and Clinical Health Act of 2009.

Please read the following and sign below:

- **PRIVACY PRACTICES**: I have read and understand the ABC Vision Source privacy policy (HIPAA Notice).
- We will bill your insurance as a courtesy to you. However, you are still responsible for your account.
- We will not bill any insurance for less than $30. A statement will be provided so that you may submit it for reimbursement.
- If your insurance does not pay or pays less than expected, it is your responsibility.
- A minimum of $30.00 fee will be assessed for any NSF checks.
- **ASSIGNMENT and RELEASE**: I request that payment from my insurance company, if applicable, be made on my behalf to my providing doctor.

  I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

SIGNATURE (of Responsible Party) ____**Date**________________