



Patient Information

Date _____

Patient _____

Address _____

City State Zip

Sex: M F Age _____ Birth date _____

Single Married Widowed Separated Divorced

Home Phone _____

Cell Phone _____

Work Phone _____

Patient SS # _____

Email Address _____

Occupation _____

Employer _____

Employer Address _____

Spouse's Name _____

Birthdate _____ SS # _____

Occupation _____

Spouse's Employer _____

Insurance

Who is responsible for this account? _____

Relationship to Patient _____

Vision Insurance (VSP, EYEMED, DAVIS.ETC.)

Name of Insurance _____

Member ID # _____

Subscribers Name _____

Employer _____

Birth date _____ SS# _____

Medical Insurance (ALTIUS, BLUE CROSS, MEDICARE ETC)

Name of Insurance _____

Member ID # _____

Subscribers Name _____

Employer _____

Birth date _____ SS# _____

In case of Emergency, Contact _____

Name

Relationship

Home phone Cell Phone Work Phone

Eye Health History

Previous Eye Dr. _____	Bloodshot eyes	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Headaches	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Date of Last Exam _____	Blurred Vision- Near/Far	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Itching Eyes	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Do you wear Glasses? YES No	Burning Eyes	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Light Sensitive	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
All the time Occasionally Reading Driving TV	Cataracts	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Loss of Vision	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Do you wear Contacts? YES NO	Crossed Eyes	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Migraine Headaches	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Type _____	Discharge from Eyes	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Night Vision, Poor	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
hours/day _____	Dizzy Spells	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Red Eyes	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Describe any problems you have with your contacts _____	Double Vision	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Seeing Halos	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
_____	Dry Eyes	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Seeing Flashes	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
	Eye Injury	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Temporary Loss of Vision	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
	Eye Strain	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Vision Poor	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
	Fainting spells, Blackouts	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Twitching Eyelid	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

Health History

	Yourself				Family Members			Yourself				Family Member	
	Yes	No	Yes	No	Yes	No		Yes	No	Yes	No	Yes	No
AID/HIV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis (type ____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Artificial joints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lazy Eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Migraine Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pace Maker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor Color Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Retinal Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chemical Dependency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shingles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drug Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin Conditions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Conditions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Turned Eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you Pregnant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Primary Care Physician _____

Medications

List Medications you are currently taking, Including Eye Drops:

Allergies

List your allergies to medications or other substances

Financial Terms

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I authorize Jordan Vision Clinic to release any part of my medical record required to process an application for payment for services rendered or medical supplies delivered to my health insurance company or other third party payer.

AUTHORIZATION TO ASSIGN BENEFITS

I authorize and assign benefits from my Health insurance company or third party payer to be paid directly to Jordan Vision Clinic.

GUARANTOR RESPONSIBILITY AND 3rd PARTY LIABILITY

I Accept responsibility for payment of all charges resulting from my medical evaluation and treatment. This includes charges for medical evaluation, any medical procedure performed, medical supplies given or administered. Where the payment allowed by my health insurance for any service is less than the charge for that service. I agree to pay the balance of the full charge. I understand that payment is due at the time of service. I agree to pay any co-payment or deductible amount required by my health insurance policy at the time of service. I understand that an insurance claim form will be submitted to my primary health insurance company by the staff of Jordan Vision Clinic.

I agree to pay a monthly finance charge of 1.5% (18% annual Interest rate) or \$2.00, whichever is greater on any balance on my account that is outstanding for over 90 days. I agree to pay a \$30 penalty fee for any check that I write that is returned for insufficient funds. I agree to make payment in full for services performed within 90 days. I agree to make payment in full for services performed within 90 days of the date of service. I understand that failure to make payment within this time may result in the referral of my account to a collection agency. In the event that collection or legal action is taken by Jordan Vision Clinic to obtain payment for up to 40% of the total bill, with or without suit, attorneys fees, court costs and other expenses that result from such action.

I accept responsibility for obtaining any written referral, or prior approval, or authorizations for service required by my health insurance company or other third party payer. I agree to pay the full costs of any service which is either disallowed by health insurance company or which is not paid because such prior authorization was not obtained.

I certify that I have read this agreement and by my signature, I agree to the terms set forth above.

Guarantor's Signature _____ Date _____
(must be 18 years old)

Print Guarantors name _____ Relationship to Patient _____