South Holland Vision Center

Welcome To Our Office

Today's Date _____

Name _____

Address _____

City _____ State _____ Zip _____

Cell Phone _____ Home Phone _____ Work Phone

Email Address _____

Social Security Number _____ - _____ - _____ Date of Birth _____ / _____ / _____

Employer (or School) _____ Occupation (or Grade) _____

VISION INSURANCE

Vision Insurance Company: None VSP EyeMed Davis Other _____

Insurance ID Number _____ Group # _____

Insured's Relationship to Patient: Self Parent Spouse Other _____

Insured's Name (if not Patient) _____ Insured's Date of Birth _____ / _____ / _____

Social Security Number _____ - _____ - _____ Insured's Address _____

City _____ State _____ Zip _____ Phone _____

PRIMARY MEDICAL INSURANCE

Medical Insurance Company: None Medicare Medicaid BC/BS Other _____

Insurance ID Number _____ Group # _____

Insured's Relationship to Patient: Self Parent Spouse Other _____

Insured's Name (if not Patient) _____ Insured's Date of Birth _____ / _____ / _____

Social Security Number _____ - _____ - _____ Insured's Address _____

City _____ State _____ Zip _____ Phone _____

ADDITIONAL (SUPPLEMENTAL) MEDICAL INSURANCE

Supplemental Insurance Company: None Medicare Medicaid BC/BS Other _____

Insurance ID Number _____ Group # _____

Insured's Relationship to Patient: Self Parent Spouse Other _____

Insured's Name (if not Patient) _____ Insured's Date of Birth _____ / _____ / _____

Social Security Number _____ - _____ - _____ Insured's Address _____

City _____ State _____ Zip _____ Phone _____

INSURANCE AUTHORIZATION

I request that payment of authorized Medicare (or other insurance) benefits be made or on my behalf to South Holland Vision Center for any services furnished to me. I authorize any holder of medical information about me to release to the CMS and its agents, or other medical insurance and their agents, any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorize release of medical information necessary to pay the claim. If "other health insurance" is indicated on approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and I, the patient, am responsible for the deductible, coinsurance, and non-covered services. Coninsurance and the deductible are based upon charge determination of the Medicare carrier (or my other insurance company).

Signature (Insured Patient or Guardian) _____ Date _____

The information in this confidential case history form is critical to the evaluation of your vision and health.

PATIENT MEDICAL HISTORY

Name of Family Physician _____

Town _____

Date of Last Physical Check-up _____

CURRENT MEDICATIONS (Rx or Over the Counter)

(List name of medications including eye drops, vitamins, and birth control pills)

_____

_____

Allergies to medications? ❑ Yes ❑ No

If so, what medications? _____

_____

Have you had any surgeries? ❑ Yes ❑ No

Do you use cigarettes/tobacco, alcohol, or any other substances? ❑ Yes ❑ No

Have you ever been diagnosed or treated for the following health problems?	**YES**	**NO**
Allergies	❑	❑
Arthritis	❑	❑
Blood/Lymph	❑	❑
Bronchitis	❑	❑
Cancer	❑	❑
Cholesterol	❑	❑
Diabetes	❑	❑
Digestive	❑	❑
Ears/Nose/Throat	❑	❑
Endocrine	❑	❑
Eczema/Rashes	❑	❑
Fatigue	❑	❑
Fevers	❑	❑
Genitourinary	❑	❑
High Blood Pressure	❑	❑
Integumentary (Skin)	❑	❑
Kidney	❑	❑
Muscle/Bone	❑	❑
Neurological	❑	❑
Psychological	❑	❑
Respiratory	❑	❑
Sinus	❑	❑
Throat Infections	❑	❑
Thyroid	❑	❑
Unusual weight losses/gains	❑	❑

PATIENT EYE HISTORY

Date of Last Eye Exam _____

By Whom? _____

Have you ever tried contact lenses? ❑ Yes ❑ No

Do you currently wear contact lenses? ❑ Yes ❑ No

What kind? _____

Solutions used _____

Are you satisfied with the vision and comfort of your contact lenses? ❑ Yes ❑ No

Would you prefer clear contact lenses or colored contact lenses? ❑ Clear ❑ Colored

FAMILY MEDICAL/EYE HISTORY (Check all that apply)

Is there a family medical history of any of the following:

❑ **NO** ❑ **YES** *(please check boxes)*

	Relationship (Mother's or Father's side)
Blindness	❑ _____
Cataracts	❑ _____
Corneal Problems	❑ _____
Diabetes	❑ _____
Glaucoma	❑ _____
Heart Disease	❑ _____
Lazy Eye	❑ _____
Macular Degeneration	❑ _____
Retinal Problems	❑ _____

How did you hear about our office?

❑ Friend or Relative Who? _____

❑ Building Sign

❑ Yellow Pages – which directory?

❑ Civic Group or Community Event Which? _____

❑ Previous Patient Who? _____

❑ Insurance

❑ Internet Where? _____

❑ Other _____

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone.

Signature is only acknowledgement that you have received this Notice of our Privacy Practices:

Signature _____ Date _____