WELCOME TO TOTAL VISION

Date _____ DOB _____ Age _____ Sex M F

Name _____ (PLEASE PRINT)

Mailing Address _____ Employer (or School) _____

City _____ State ___ Zip _____ Occupation (or Grade) _____

Home Phone _____ Spouse or Parents Name _____

Work Phone _____ Children _____

Cell Phone _____ Email _____

May we contact you by email? Yes No

Patient Eye History
(Check all that apply)

- ☐ Eye Disease
- ☐ Eye Injury
- ☐ Eye Surgery
- ☐ Lazy Eye
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Other: _____

Patient Medical History
(Check all that apply)

- ☐ Asthma
- ☐ Arthritis
- ☐ Blood Pressure
- ☐ Cancer
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Thyroid
- ☐ Other: _____

Family Medical/Eye History
(Check all that apply)

Relationship

- ☐ Blindness _____
- ☐ Cataracts _____
- ☐ Glaucoma _____
- ☐ Macular Degeneration _____
- ☐ Diabetes _____
- ☐ Heart Disease _____
- ☐ Other _____

Medications:

Allergies

Physician _____

Reason for today's visit

What is the **primary** purpose of this visit?

_____

When did you first notice this problem?

_____

Do you experience any of the following?

- ☐ Blurred Vision
- ☐ Headaches
- ☐ Flashing Lights
- ☐ Computer Problem
- ☐ Sports Vision Problem
- ☐ Infection/Red or Painful Eye
- ☐ Other Eye Problem

Do you... (Check all that apply)

- ☐ Work at a Computer? ____ Hours/day
- ☐ Have prescription sun glasses?
- ☐ Want info on laser vision correction?
- ☐ Have an interest in non-surgical approach to vision correction?
- ☐ Have more than one pair of Rx glasses?
- ☐ Participate in Recreation/Sports?
- ☐ Need new glasses
- ☐ Need new contact lenses

What are your hobbies?

_____

_____

How did you first hear about Total Vision?

- ☐ Referred by friend/relative
  If so, whom? _____
- ☐ Referred by health care practitioner
  If so, whom? _____
- ☐ Civic Group or Community Event
  If so, which? _____
- ☐ Yellow Pages / Which Directory? _____
- ☐ Web page
- ☐ Newspaper advertisement
- ☐ Office Signage
- ☐ Radio
- ☐ Insurance Company

If you wear glasses:

- Are there times you would rather not have to wear them? Yes No
- Would you like them thinner and lighter? Yes No
- Are you bothered by bifocal lines and head tilting? Yes No
- Are they 100% UV protected? Yes No
- Do you tend to scratch your lenses? Yes No
- Are you bothered by glare? Yes No

Contact lenses:

- Ever worn contact lenses? Yes No
- Interested in contact lenses? Yes No

Insurance Information

Vision Insurance

- ☐ VSP
- ☐ VCI
- ☐ EyeMed
- ☐ Other: _____

Subscriber Name: _____

Subscriber SSN: _____

Subscriber Birth Date: _____

Do you participate in a FSA? Yes
No

How will you settle your account today?

☐ Cash ☐ Check ☐ Credit Card

Primary Medical Insurance

- ☐ Medicare
- ☐ Medicaid
- ☐ Blue Cross PPC
- ☐ Major Medical
- ☐ Florida Health Care
- ☐ Healthy Kids
- ☐ Champus
- ☐ Volusia Health Network
- ☐ Blue Cross/Blue Shield
- ☐ Other: _____

Subscriber Name: _____

Subscriber SSN: _____

Subscriber Birth Date: _____

(It is customary to pay professional fees, including co-payments, when services are rendered. Verification of covered deductible is required.)

PLEASE ASK FOR AN INSURANCE REPORT IF YOU HAVE A MAJOR MEDICAL PROVIDER

I, the undersigned, hereby acknowledge that I have read and understand the payment policies of this office as outlined above. I also agree that all payments for services be made at each visit. Also, I am responsible for payment of all services rendered by the doctors of Total Vision which are not covered by Medicare assignment, Medicaid, Workman's Compensation, or other benefits agreed by the provider of such services.

Signature _____ Date _____

(Please ask our receptionist if you have any questions. Thank you)

LIFETIME INSURANCE AUTHORIZATION

MEDICARE AND ACCEPTED MAJOR MEDICAL INSURANCE

I request that payment of authorized Primary and Supplement Insurance benefits be made either to me or on my behalf for any service furnished by my doctor at Total Vision.

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

Signature _____ Date _____