ADVANCED VISION CARE, LLC ***Dr. Joshua D. Wilson*** ***Dr. Michael E. Gewe***

PLEASE PRESENT THIS INFORMATION ALONG WITH INSURANCE CARDS AND PHOTO IDENTIFICATION UPON OFFICE ARRIVAL

Name: _____ Nickname: _____ Gender: M / F

Date of Birth: _____/_____/_____ Social Security # _____-_____-_____

Address: _____ City: _____ State: _____ Zip: _____

Phone: Home: (___)_____ Cell: (___)_____ Work: (___)_____

May we send text messages to your cell? Y / N Email: _____

Preferred method of contact ? CALL (Home / Cell / Work) / TEXT / EMAIL

Occupation: _____ Employer: _____

Employment Status: Retired: _____ Full-Time: _____ Part-Time: _____ Unemployed: _____

Marital Status: S / M / D / W Children's Names & Ages:_____

Spouse: _____ Spouse's DOB: _____/_____/_____ Spouse's SSN: _____-_____-_____

Spouse's Employer: _____ Spouse's Employer Phone: (___)_____

If a patient is a minor, please enter responsible party information: (Note we do not bill absent parents, the adult presenting the minor is the responsible party.)

Responsible Party: _____ Employer: _____

Responsible Party's DOB: _____ Responsible Party's SSN: ____-____-_____

Policy Holder (**if different from responsible party**): _____

Policy Holder's DOB: _____/_____/_____ Policy Holder's SSN: _____/_____/_____

Employer of Policy Holder: _____ Work Phone: (____)_____

Patient's Relationship to Policy Holder: _____

May we share patient information with another person not listed above? Y / N

If yes, whom? _____

Patient Name: (Printed) _____

Patient/Guardian Signature: _____ Date: ____/___/_____

SOCIAL HISTORY

Do you use tobacco products? Y / N Drink alcohol? Y / N Use any illegal or recreational drugs? Y / N
If yes to any of above, type/amount/how long? _____

OCULAR HISTORY

How long since last eye exam ?_____ Doctor who performed exam: _____

Wear glasses? Y / N If so, how old is current pair?_____ Wear contact lenses? Y / N

If yes, what type (soft, gas perm, etc) & brand? _____ Sleep in them? Y / N / Occasionally

If you don't wear contacts, are you interested in them? Y / N Interested in refractive surgery? Y / N

Please specify if you personally or a family member has a history of the following:

EYES:	YES	NO	FAMILY, WHO?	EYES:	YES	NO	FAMILY, WHO?
Cataracts	[ ]	[ ]	[ ] _____	Blurred Vision	[ ]	[ ]	[ ] _____
Glaucoma	[ ]	[ ]	[ ] _____	Double Vision	[ ]	[ ]	[ ] _____
Macular Degeneration	[ ]	[ ]	[ ] _____	Floaters/Flashes	[ ]	[ ]	[ ] _____
Loss of Vision	[ ]	[ ]	[ ] _____	Lazy Eye	[ ]	[ ]	[ ] _____
Dryness	[ ]	[ ]	[ ] _____	Itching	[ ]	[ ]	[ ] _____
Burning	[ ]	[ ]	[ ] _____	Excess Tearing	[ ]	[ ]	[ ] _____
Mucous Discharge	[ ]	[ ]	[ ] _____	Eye Pain	[ ]	[ ]	[ ] _____
Light Sensitivity	[ ]	[ ]	[ ] _____	Redness	[ ]	[ ]	[ ] _____
Color Blindness	[ ]	[ ]	[ ] _____	Retina Problems	[ ]	[ ]	[ ] _____

Primary Care Physician: _____ Location/City: _____

Specialty Physician (e.g. Endocrinologist): _____ Location: _____

Pharmacy: _____ Location: _____

Please list ALL medications you are currently taking along with dosage, route, and reason (include OTC and eye drops):

Medication: _____ Dosage: _____ Route: _____
Medication: _____ Dosage: _____ Route: _____
Medication: _____ Dosage: _____ Route: _____
Medication: _____ Dosage: _____ Route: _____
Medication: _____ Dosage: _____ Route: _____
Medication: _____ Dosage: _____ Route: _____
Medication: _____ Dosage: _____ Route: _____
Medication: _____ Dosage: _____ Route: _____

Do you have any allergies to medications? Y / N
If yes, please list & explain type of reaction: _____

Please list all major surgeries & injuries, including dates: _____

Have you had any eye injuries, surgeries, or other significant eye problems (include dates)

_____

_____

_____

MEDICAL HISTORY

CONSTITUTIONAL	YES	NO	FAMILY, WHO?
Weight Fluctuation	[ ]	[ ]	[ ] _____
Sleep Disorder	[ ]	[ ]	[ ] _____
Developmental Disorder	[ ]	[ ]	[ ] _____
Fever/Chills	[ ]	[ ]	[ ] _____
Fatigue	[ ]	[ ]	[ ] _____
Trauma	[ ]	[ ]	[ ] _____

Other _____

EAR/NOSE/THROAT	YES	NO	FAMILY, WHO?
Sinus Problems	[ ]	[ ]	[ ] _____
Ringing	[ ]	[ ]	[ ] _____
Vertigo	[ ]	[ ]	[ ] _____

Other _____

NEUROLOGIC	YES	NO	FAMILY, WHO?
Headaches	[ ]	[ ]	[ ] _____
Memory Loss	[ ]	[ ]	[ ] _____
Epilepsy/Seizures	[ ]	[ ]	[ ] _____
Stroke	[ ]	[ ]	[ ] _____

Other _____

PSYCHIATRIC	YES	NO	FAMILY, WHO?
Depression	[ ]	[ ]	[ ] _____
Anxiety	[ ]	[ ]	[ ] _____
Sleep Troubles	[ ]	[ ]	[ ] _____

Other _____

CARDIOVASCULAR	YES	NO	FAMILY, WHO?
Heart Disease	[ ]	[ ]	[ ] _____
High Blood Pressure	[ ]	[ ]	[ ] _____
Vascular Disease	[ ]	[ ]	[ ] _____

Other _____

RESPIRATORY	YES	NO	FAMILY, WHO?
Asthma	[ ]	[ ]	[ ] _____
Bronchitis	[ ]	[ ]	[ ] _____
Emphysema	[ ]	[ ]	[ ] _____
COPD	[ ]	[ ]	[ ] _____

Other _____

GASTROINTESTINAL	YES	NO	FAMILY, WHO?
Crohn's	[ ]	[ ]	[ ] _____
Ulcer	[ ]	[ ]	[ ] _____
Digestive/IBS	[ ]	[ ]	[ ] _____
Eating Disorder	[ ]	[ ]	[ ] _____

Other _____

GENTOURINARY	YES	NO	FAMILY,WHO?
Pregnancy	[ ]	[ ]	[ ] _____
STD	[ ]	[ ]	[ ] _____

If yes, list _____

Other _____

MUSCULOSKELETAL	YES	NO	FAMILY,WHO?
Arthritis	[ ]	[ ]	[ ] _____
Rheumatoid Arthritis	[ ]	[ ]	[ ] _____
Fibromyalgia	[ ]	[ ]	[ ] _____
Muscle/Joint Pain	[ ]	[ ]	[ ] _____

Other _____

SKIN	YES	NO	FAMILY,WHO?
Eczema	[ ]	[ ]	[ ] _____
Rosacea	[ ]	[ ]	[ ] _____
Cancer	[ ]	[ ]	[ ] _____

Other _____

ENDOCRINE	YES	NO	FAMILY, WHO?
Hypothyroidism	[ ]	[ ]	[ ] _____
Hyperthyroidism	[ ]	[ ]	[ ] _____
Type I Diabetes	[ ]	[ ]	[ ] _____
Type II Diabetes	[ ]	[ ]	[ ] _____
Insulin Dependent?	[ ]	[ ]	

Other _____

BLOOD/LYMPHATIC	YES	NO	FAMILY, WHO?
Anemia	[ ]	[ ]	[ ] _____
Sjogren's	[ ]	[ ]	[ ] _____
Bleeding Disorder	[ ]	[ ]	[ ] _____
Leukemia	[ ]	[ ]	[ ] _____

Other _____

ALLERGIES	YES	NO	FAMILY, WHO?
Food	[ ]	[ ]	[ ] _____
Seasonal	[ ]	[ ]	[ ] _____
Other	[ ]	[ ]	[ ] _____

PATIENT SIGNATURE:

_____

DATE: _____/____/_____

PHYSICIAN INITIALS _____

We are committed to providing you with the best possible care. This information is designed to guide you through the rapidly changing world of optometry and insurance plans. Please read carefully and sign the bottom of the page indicating your understanding and acceptance of our policies and procedures.

PAYMENT IS DUE AT THE TIME OF SERVICE UNLESS PAYMENT ARRANGEMENTS HAVE BEEN APPROVED BY ADVANCED VISION CARE.

I understand I may be seen by Advanced Vision Care, LLC without pre-authorization from my vision and/or medical insurance and, possibly, without a referral from my primary care physician. I understand I am financially responsible if my eligibility cannot be verified and/or I do not obtain the proper referral form when required. The filing of a claim for any service rendered DOES NOT GUARANTEE payment from my insurance company. Having more than one insurer DOES NOT mean that services are covered 100%. Billing secondary insurance is a courtesy.

We must emphasize that as health care providers, **our relationship is with you,** not your insurance company.

YOU MUST REALIZE THAT:

1. **Your insurance is a contract between you, your employer, and the insurance company. We are not included in your contract.**
2. **Not all services are covered by all insurance policies. Some companies select certain services that they will not cover.**
3. **The "Usual and Customary Charges" that may be quoted by your insurance company are charges that have been determined and set by your insurance company. They do not necessarily reflect our fees.**

I understand that I am financially responsible for any and all services rendered, including those not covered under the terms of my insurance policy. I also understand that I will pay all reasonable attorney and/or collection fees incurred as a result of collection action for amounts due for any services rendered.

I hereby authorize Advanced Vision Care, LLC to release to or obtain from my insurance company, any medical facility, or physician involved in my care, information acquired in the course of my treatment. I authorize any holder of medical information pertaining to me to release to Medicare or other insurance carriers and its agents any information needed to determine these benefits or the benefits payable for related services, and authorize payment to Advanced Vision Care, LLC on my behalf.

A refraction is testing done in addition to your ocular health exam in order to determine the correction necessary to properly focus and optimize vision clarity and comfort. It is not considered a medical procedure, and therefore, is not covered by Medicare and most other medical insurance plans. Charges for this procedure range from $20.00 - $40.00, depending on the complexity. I understand that I am responsible for this charge.

I acknowledge Advanced Vision Care, LLC's Notice of Privacy Practices has been presented to and/or made available to me. I understand Advanced Vision Care reserves the right to change their privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be made available to me or provided upon request.

Signature on File: This authorization will remain in force and effect until revoked by me in writing.

Patient/Guardian Signature: _____ Date: _____