TODAY'S VISION
THE ONE TO SEE®

Last Name_____**First Name**_____**MI**_____

Date of Birth (mm/dd/yyyy)_____ **Nickname**_____

Mailing address _____

City _____ **State** _____ **Zip Code** _____

Email _____

Occupation_____ **Employer**_____ **Referred By**_____

Phone number _____ □ Okay to text

HISTORY

Date of last eye exam _____**Doctor's name** _____**Location** _____

Do you wear glasses? □ No □ Full-time □ Part-time If part time, how often/when?_____

Do you wear contacts? □ No □ Full-time □ Part-time If part-time, how often? _____

Current Brand_____□ soft □ rigid gas permeable

Replacement schedule _____**How old is current pair**?_____

Are your lenses comfortable? □ No □ Yes

Do you have any problem with your contacts? □ Dryness □ Itchiness □ Redness □ Poor vision

Do you sleep with your contacts on? □ Yes □ No How often? _____

How many hours a day you use computer?_____

Describe any visual symptoms from computer use:_____

Are you currently experiencing any of the following?

Headaches	□ yes	□ no	Halos around lights	□ yes	□ no	Gastrointestinal	□ yes □ no
Blurred Vision	□ yes	□ no	Light sensitivity	□ yes	□ no	Ears/Nose/Throat	□ yes □ no
Double Vision	□ yes	□ no	Frequent styes	□ yes	□ no	Cardiovascular	□ yes □ no
Eye pain or tired	□ yes	□ no	Red eyes	□ yes	□no	Allergic/Immunologic	□ yes □ no
Floaters	□ yes	□ no	Eyes itch	□ yes	□no	Skin	□ yes □ no
Flashing lights	□ yes	□ no	Eyes burn	□ yes	□no	Blood/Lymph	□ yes □ no
Eyes feel sandy	□ yes	□ no	Eyes tear	□ yes	□no	Muscles/bones	□ yes □ no
						Pregnant/Nursing	□ yes □ no

Personal medical history

Have you had any eye surgery? □ Yes □ No If yes, why _____

Are you taking any eye medication? □ Yes □ No If yes, why _____

Date of last physical _____ **Doctor's name** _____

Are you allergic to any medication? □ Yes □ No If yes, what? _____

Are you taking any medication? □ Yes □No List all medication _____

_____

List any surgeries you have had: _____

Check if you or any family members have the following:

	YOU	FAMILY		YOU	FAMILY
Blindness	□	□	**Neurological**	□	□
Eye Turn (Strabismus)	□	□	**Heart Disease**	□	□
Lazy Eye (Amblyopia)	□	□	**Cancer**	□	□
Keratoconus	□	□	**Diabetes**	□	□
Macular Degeneration	□	□	**High blood pressure**	□	□
Retinal Detachment	□	□			
Glaucoma	□	□	**Relation to family of any conditions checked:**		
Cataracts	□	□	_____		
Thyroid	□	□	_____		
			_____		

Other eye or medical conditions not mentioned above: _____

_____

_____

Patient's (or Guardian) Signature: _____ Date: _____

OPTOMAP – Fee $39 **The Optomap (digital image of the retina) will be done annually for every patient UNLESS a waiver is signed.** This image will help your doctor assess your overall health and see any retinal problems you may have. Using this scan, we can retinal problems, such as macular degeneration, glaucoma, retinal holes, retinal detachments, diabetes and high blood pressure all without dilation for most patients. Our doctor wants *ALL* patients to have a digital image of the retina *EVERY* year.

Early detection is crucial!

INSURANCE AUTHORIZATION AND FINANCIAL RESPONSIBILITY

Payment Policy: It is customary to pay for professional services when rendered.

Consent to Treatment and Authorization of Charges: I am an adult 18 years of age or older, or am the parent/guardian of the minor child whose name appears below and hereby authorize TODAY'S VISION FAIRFIELD to perform such eye care and treatment on me or my minor child as it deems appropriate and consent to such care and treatment, I further authorize my child to order and purchase goods and services and agree to pay for them whether performed on me or my child.

Assignment of Benefits: I hereby assign payment of authorized insurance (Medicare, Medicaid or any other third-party payor) to which I am entitled to be made to TODAY'S VISION FAIRFIELD for any goods or services furnished. I also authorize Today's Vision to release medical information to my insurance company(ies) now or in the future for claim consideration purposes. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that the filing of a claim for any services rendered **does not guarantee payment** from my insurance company. I fully understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Patients with Insurance: Our staff will assist you in dealing with your insurance company by verifying your benefits using the member services phone number given on your insurance card; however, **this verification is not a guarantee of payment, and it is your responsibility to know and understand your own insurance benefits, coverage and authorization requirements,** Additionally, all amounts owed by patients under contracted insurance plans (co-pays, deductibles, and non-covered services) are payable at the time of service. **Any service that is rendered by this office, which is not a covered benefit under your insurance policy, is your responsibility to pay.** In order to process your insurance claim you must present your insurance card or voucher at the time of service. Failure to do so may result in denial of your claim.

_____ _____ _____

Print patient's name Signature of patient (or guardian) Date

RELEASE OF MEDICAL RECORDS:

☐ I DO authorize the release of prescription information / materials to family members or the following persons:

Name(s)_____

☐I do NOT authorize the release of prescription information / materials to family members.

HIPPA PRIVACY – ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

I understand and have been provided with an opportunity to review the *Notice of Privacy Policies* that provides a more complete description of information uses and disclosures. A copy is available upon request.

_____ _____

Patient's Signature Date