VISION CLINIC AT FOXHILL

2001 46TH AVE. GREELEY, CO 80634 **DATE:**

PATIENT INFORMATION											
Patient's last name:		First:	Middle:	❑ Mr. ❑ Mrs. ❑ Dr.	❑ Miss ❑ Ms.	Marital Status (Circle One) Single / Mar / Div / Sep / Widowed					
Is this your legal name?		If not, what is your legal name?	Height:_____		Birth date:		Age:	Sex:			
❑ Yes	❑ No		Weight:_____		/ /			❑ M	❑ F		
Street address:			Social Security no.:			Cell Phone ( ) Home Phone ( )					
P.O. box:	City:		State:	ZIP Code:		Email:					
Occupation:		Employer:					Preferred Communication (Circle One)				
Medical Doctor:_____		Last Eye Exam:_____ Last Eye Doctor:_____					Cell/Home/Email/Postal/Text				

*There are areas of the retina that cannot be seen without the OptoMap Retinal Exam or Dilation. A wide-field view Is important in detecting macular degeneration, glaucoma, diabetes, tumors, and retinal detachments. **Choose one:**

❑ I would like the Optomap Retinal Exam (Picture, No side effects, see bottom laminate page for more information)
❑ I would like Dilation (With drops, you will have blurry vision and light sensitivity and may require a driver)

INSURANCE INFORMATION											
(Please give your insurance card to the receptionist.)											
Name of Insured:	Vision Insurance Company:	Birthdate:	Group no.	Policy no.							
		/ /									
Patient's relationship to subscriber:	❑ Self	❑ Child	❑ Other	❑ Spouse	Social Sec. of Policy Holder:						
Name of Primary Insurance (if applicable):	Subscriber's name:			Major Medical Company: _____	Policy no.:						
If you have Medicare Medicare Number:_____	Supplemental Insurance:_____ (We must have your cards to make photocopies)										

Guardian or Spouses Name_____ Phone:_____

Financial Responsibility (Person Financially Responsible for Patient named Above)
I understand that Vision Clinic at Foxhill does not participate with some insurance companies and that payment is due at the time services are rendered. I agree to these payment terms and guarantee payment to Vision clinic at Foxhill for any services provided to this patient named above. A rebilling (finance charge) of $0.75 minimum, maximum 1.5% per month, 18% per annum is added to an account when payment is not made as agreed or arrangements changed or when no payment has been received within the last month.

_____ _____
Signature of Guarantor Date

The submitting of insurance claims by Vision Clinic at Foxhill is a courtesy to our patients. We will provide the information requested by the insurance carrier, however, should the insurance carrier refuse payment the account is the responsibility of the patient.

Patient or authorized persons signature
I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits or insurance reimbursement to any party who accepts assignment of the claim or to myself if assignment is not accepted. By providing us with your landline or cell phone number(s), you give express authorization to contact you at those numbers. This applies to any future landline or cell phone number. Phone calls to you may utilize automated dialer technology. Providing your phone number is not a condition of receiving our services

_____ _____
Signature Date

Medical History

What is the reason for your visit today?_____
List any medications you take. If you have a list of medications we will make a copy. (Please include eye drops, aspirin, over the counter medications) _____
_____
Do you have any allergies to medications? ❑ Yes ❑No If yes, list and describe any reactions_____
_____
Circle any of the following that you have had: Crossed eyes, Lazy eye, glaucoma, retinal disease, cataracts, eye infections, eye injury.
Are you pregnant? ❑ Yes ❑ No If yes, how far along? _____
Do you wear glasses? ❑Yes ❑ No if yes, how old is your present pair? _____
Do you wear contact lenses? ❑ Yes ❑ No if yes, how old is your present pair? _____
Type of Lenses: ❑ Rigid ❑Soft On a scale of 1 to 10, how comfortable are your contact lenses? _____
Do you use/have used tobacco products? ❑ Yes ❑ No If yes, type/how long?
_____
Do you drink alcohol? ❑ Yes ❑ No How often_____
Have you ever been exposed to or infected with (check those that apply): ❑ Hepatitis ❑ HIV

Please Check any of the following that apply to the patient

❑Eye Redness	❑Dryness	❑Gout	❑Asthma
❑Loss of Vision	❑Sandy/Gritty Eyes	❑Headaches	❑Emphysema/COPD
❑Blurred Vision	❑Itching	❑Migraines	❑High Blood Pressure
❑Flashes	❑Burning	❑Seizures	❑Heart Disease
❑Color Vision Probs.	❑Excess Watering	❑Depression	❑Arthritis
❑Floaters	❑Glare/Light Sensitivity	❑Thyroid	❑High Cholesterol
❑Double Vision	❑Eye Pain or Soreness	❑Diabetes	❑Immunological
❑Night Vision Probs.	❑Chronic Eye Infection	❑Memory Loss	❑Allergies/Hayfever

Family History

Condition	Relation to You	Condition	Relation to You
❑Blindness		❑High Blood Pressure	
❑Cataract		❑Arthritis	
❑Glaucoma		❑Diabetes	
❑Macular Degen.		❑Heart Disease	
❑Retinal Detachment		❑Cancer	

Race: ❑Hispanic ❑White ❑Asian ❑Black or African American
❑Native Hawaiian/Other Pacific Islander ❑American Indian/Alaskan Native

Ethnicity: ❑Hispanic or Latino ❑Not Hispanic or Latino ❑Native Hawaiian/Other Pacific Islander

Other Health History
_____
_____
_____
_____