LifetimeVision
& CONTACT LENS CENTER

Patient Financial Information Sheet

I understand that payment in full is due at time of service unless other arrangements have been made.

Name of Patient: _____ **DOB**_____

Name of Insured: _____ **DOB**_____

If No Insurance Card is Available please supply the Insurance Carrier and ID #

Name of Primary Health Insurance Carrier: _____

ID#:_____ **Policy #:**_____

Name of Secondary Health Insurance Carrier: _____

ID#:_____ **Policy #:**_____

Name of Vision Insurance Carrier: _____

ID#:_____ **Policy #:**_____

Insurance Card Copied: _____ Yes _____ No _____ No Card

Authorization and Release:

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or other health practitioners.

I authorize and request my insurance company to pay directly to the doctor insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

I authorize the release of any information including the diagnosis and the records of any treatment or examinations rendered to me or my child to: _____

_____ _____

Signature of patient or parent if minor Date

HIPAA Privacy Practice acknowledgement

I have received or was offered and declined a notice of privacy practices.

Signature: _____ **Date:** _____

Medical History Questionnaire

LifetimeVision & CONTACT LENS CENTER

General Information

Date: _____/_____/_____

Last Name_____ First Name: _____M _____DOB: ____/____/____

M or F SSN: _____/_____/_____ Marital Status: Married / Single / Divorced / Widowed

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

Home Ph: ( ) _____ Work Ph: ( ) _____ Cell Ph: ( ) _____

Employer/School:_____ Occupation/School Grade:_____

E-mail Address: _____ Sports/Hobbies: _____

Emergency Contact: _____ Relation: _____ Phone #: ( ) _____

CASE HISTORY / REASON FOR VISIT:

Date of Last Medical Exam:____/____/____ Primary Physician/Clinic:_____

Date of Last Eye Exam:_____/_____/_____ Clinic/Eye Doctor's Name:_____

Do you wear glasses? Yes/No/All the time/Sometimes/Work Only/Reading only/Driving only

How old are your present glasses: _____ Do you wear prescription Sun Wear: Yes/No

Do you wear contacts? Yes No Type:_____ Solution Used: _____

Wearing schedule: **Daily** **Overnight** Replacement schedule: **Daily** **2 week** **Monthly** **Yearly**

Have you ever had eye injuries? Yes No Which Eye?_____

Have you ever had eye surgeries? Yes No Why?_____

Have you used eye medication? Yes No Why?_____

Are you currently pregnant or nursing? Yes No N/A

Have you ever been diagnosed with?

Cataracts: Yes/No When were you diagnosed?_____

Glaucoma: Yes/No When were you diagnosed?_____

Macular Degeneration: Yes/No When were you diagnosed?_____

What are your visual symptoms (with or without glasses or contacts)? Please circle any that apply:

Please indicate Right, Left or Both, along with severity 1(Low) 2 (Moderate) 3 (High)

In Example: [2] Eye Strain R L (B) This example indicates a moderate severity in both eyes

[ ] Blurred Vision/Distance	R L B	[ ] Dry Eyes	R L B	[ ] Headaches	R L B
[ ] Blurred Vision/Near	R L B	[ ] Red Eyes	R L B	[ ] Migraine Headaches	R L B
[ ] Double Vision	R L B	[ ] Watery Eyes	R L B	[ ] Loss of Vision	R L B
[ ] Eye Strain	R L B	[ ] Wandering eye	R L B	[ ] Crossed Eyes	R L B
[ ] Eye Infections	R L B	[ ] Mucus Discharge	R L B	[ ] Light Sensitive	R L B
[ ] Eye Pain/Soreness	R L B	[ ] Floaters or Spots	R L B	[ ] Sandy/Gritty Feeling	R L B
[ ] Tired eyes	R L B	[ ] See Flashes	R L B	[ ] Poor Color Vision	R L B
[ ] Burning Eyes	R L B	[ ] See Halos	R L B	[ ] Droopy Lid	R L B
[ ] Itchy Eyes	R L B	[ ] Poor Night Vision	R L B		

Please turn over and complete other side

PERSONAL MEDICAL HISTORY (REVIEW OF SYSTEMS) : PLEASE CHECK IF ANY OF THE FOLLOWING **APPLIES** TO YOU, AND LIST ANY MEDICATIONS FOR EACH CONDITION THAT YOU CHECK. IF YOU HAVE NONE OF THESE CONDITIONS, **PLEASE CHECK NONE.**

Cardiovascular: __ None ___ Hypertension ___ Stroke ___ Heart Disease ___ Vascular Disease ___ Other:	**Endocrine:** ___ None ___ Non-Insulin Dependent Diabetes ___ Insulin Dependent Diabetes ___ Thyroid Problem ___ Hormonal Dysfunction ___ Other:	**Respiratory:** __ None ___ Asthma ___ Bronchitis ___ Emphysema ___ COPD ___ Other:
Constitutional: __ None ___ Cancer ___ Trauma/Large Volume Blood Loss ___ Developmental Disability ___ Other:	**Ocular** __ None ___ Glaucoma ___Macular Degeneration ___Detached Retina ___ Other:	**Psychiatric:** __ None ___ ADHD ___ Depression ___ Schizophrenia ___ Other:
Neurological: __ None ___ Multiple Sclerosis ___ Epilepsy ___ Cerebral Palsy ___ Tumor ___ Other:	**Musculoskeletal:** __ None ___ Osteoarthritis ___ Fibromyalgia ___ Muscular Dystrophy ___ Ankylosing Spondylitis ___ Other:	**Immunologic:** __ None ___ AIDS or HIV ___ Rheumatoid Arthritis ___ Lupus ___ Neurofibromatosis ___ Other:
Hematological: __ None ___ Anemia ___ Leukemia ___ Other:	**Gastrointestinal** __ None ___ Crohn's ___ Colitis ___ Other:	**Ear/Nose/Throat:** __ None ___ Hearing Loss ___ Upper Respiratory Infection ___ Other:
Dermatologic: __ None ___ Eczema ___ Rosacea ___ Psoriasis ___ Other:	**Allergies** (please list) __ None Drug: Environmental:	**Alcohol Use:** Y N Amount: **Tobacco Use:** Y N Amount:

Please list physical reaction's to above allergies: _____

_____

Please list any medications and/or drugs that you are taking (including herbal) : See Attatched List: _____

1	**For**	**6**	**For**
2	**For**	**7**	**For**
3	**For**	**8**	**For**
4	**For**	**9**	**For**
5	**For**	**10**	**For**

FAMILY HISTORY: Has anyone in your family (grandparents, parents, siblings, children, living or deceased) been diagnosed with:

DISEASE / CONDITION		WHO	DISEASE / CONDITION		WHO
Retinal Detachment:	Yes/No	_____	Blindness:	Yes/No	_____
High Blood Pressure:	Yes/No	_____	Cataracts:	Yes/No	_____
Diabetes:	Yes/No	_____	Glaucoma:	Yes/No	_____
Cancer:	Yes/No	_____	Crossed Eyes:	Yes/No	_____
Heart Disease:	Yes/No	_____	Macular Degen:	Yes/No	_____
Thyroid Disease:	Yes/No	_____	Lupus	Yes/No	_____

Reviewed by:

Dr _____ Date _____