

Mount Vernon Vision Source

Welcome Back To Our Office

Welcome to Mount Vernon Vision Source. Thank you for choosing us for your eyecare needs. We are delighted to have you as a patient and appreciate the confidence you placed in us. Please take a moment to review / complete the following information to ensure that it is current and accurate. If you have any questions, please do not hesitate to ask.

Mr. Miss Mrs. Ms. Male Female

First Name MI Last Name Preferred Name

Street Address City State Zip

Social Security Number Date of Birth Home Phone - Include Area Code Cell Phone

Email Address (optional) Guardian Person Responsible for Account

Emergency Contact Emergency Phone

PRIMARY INSURANCE INFORMATION

Name and Address of Primary Insurance Company City State Zip

Insured's First Name MI Insured's Last Name M F

Insured's Identification Number Group Number Insured's Date of Birth

Patient Relationship to Insured **Patient Status**
 Self Spouse Child Other Single Married Other
 Full Time Student Part Time Student Employed

SECONDARY INSURANCE INFORMATION

Name and Address of Secondary Insurance Company City State Zip

Insured's First Name MI Insured's Last Name M F

Insured's Identification Number Group Number Insured's Date of Birth **Patient Relationship to Insured**
 Self Spouse Child Other

Please Read:

Mount Vernon Vision Source requires that the patient's portion is paid at the time services are rendered. This includes but is not limited to copays, items not payable by insurance, and any co-insurance balances. All professional services and material are charged to the patient. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old may be subject to collection fees. There will be a service charge of \$35.00 on all returned checks.

Payment from my insurance is to be paid directly to . I understand that will be billed as my primary insurance. I understand that billing any secondary insurance may become my responsibility. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed.

I acknowledge that a copy of Mount Vernon Vision Source's Notice of Privacy Practices (HIPAA) has been made available to me upon request.

Signature Date

PRIMARY CARE PHYSICIAN

Primary Care Physician and Clinic Name _____

HEALTH HISTORY

What is the main reason for today's exam ? _____ When was your last exam ? _____

When was your last health exam ? _____

Illnesses or Injuries: _____

Current Medications: _____

Current Eye Drops: _____

Medicine Allergies: _____

Mark YES to those that apply. Ones left unmarked will be considered a 'No'

EYE HISTORY

- Glaucoma Yes
- Cataract Yes
- Macular Degeneration Yes
- Retinal Detachment Yes
- Color Blindness Yes
- Headaches Yes
- Glare/Light Sensitivity Yes

- Dryness Yes
- Excess Tearing/Watering Yes
- Eye Pain or Soreness Yes
- Foreign Body Sensation Yes
- Itching Yes
- Redness Yes
- Burning Yes

- Strabismus (Crossed Eyes) Yes
- Blurred Vision Distance Yes
- Blurred Vision Near Yes
- Distorted Vision (halos) Yes
- Double Vision Yes
- Floaters or Spots Yes
- Loss of Side Vision Yes

GENERAL HEALTH CONDITION

- Respiratory (Asthma) Yes
- Gastrointestinal (stomach) Yes
- Kidney Yes
- Muscles, Bones, Joints Yes
- Skin Yes

- Fever Yes
- Weight Loss Yes
- Other Symptoms Yes
- Ears, Nose, Throat Yes
- Cardiovascular (high blood pressure etc.) Yes

- Anxiety or Depression Yes
- Thyroid, Diabetes Yes
- Blood/Lymph Yes
- Allergic Yes
- Are you? Pregnant Nursing

FAMILY HISTORY (Include only grandparents, parents, and siblings)

- Amblyopia (Lazy Eye) Yes
- Blindness Yes
- Cataract(s) Yes
- Color Blindness Yes
- Glaucoma Yes
- Macular Degeneration Yes

- Retinal Detachment Yes
- Strabismus (Eye Turn) Yes
- Arthritis Yes
- Cancer Yes
- Diabetes Yes
- Heart Disease Yes

- High Blood Pressure Yes
- Kidney Disease Yes
- Stroke Yes
- Thyroid Disease Yes
- Others Yes

Name

**Mount Vernon Vision Source
MEDICAL HISTORY QUESTIONAIRE**

SPECTACLE LENS HISTORY

CONTACT LENS HISTORY

Do you use a computer? Yes No How many hours/day? _____

Do you have glare problems? Yes No

Do you have problems with night vision? Yes No

Type of glasses worn: FullTime PartTime Distance Close

Do you wear sunglasses? Yes No

SPECIAL EYEWEAR NEEDS

Computer (special prescriptions, special anti-glare tints or coatings) Safety Glasses (gardening, woodworking, welding)
 Occupational (mechanics, plumbers, pilots) Sports/Hobbies (racquet sports, motorcycle)

CONTACT LENS HISTORY

Do you currently wear contact lenses? Yes No

If not a contact lens wearer, are you interested in trying contact lenses at this time ? Yes No

SOCIAL HISTORY

Current Occupation _____ Years _____ Employer _____

Do you smoke ? No Occasional 1/2 Pack/day 1 Pack/day 1+ Pack

Do you use Illegal Drugs : Yes No

Hobbies/ Interests : _____

In our continued efforts to bring the most advanced technology available to our patients, we offer advanced retinal imaging called EyeScreen. Additional information on the EyeScreen is on the bottom of the clipboard. EyeScreen is a high resolution screen photograph of your retina which will help to document, review, and compare your retina over time. Dr. Jones considers this excellent technology an important part of every full eye health exam.

The annual EyeScreen exam is a fast and permanent record to compare and track potential eye diseases with an in-depth view of the entire retina.

YES, I choose to do the EyeScreen photos for an additional fee of \$35.00 (children 17 and under \$20.00) due at the time of service. If Dr. Jones determines that the photos are medically necessary additional software and documentation tools will be utilized to further follow the medical condition. Insurance will be billed for the photos, which *may be subject to your medical insurance deductible* and result in out of pocket expenses.

NO, I understand that EyeScreen retinal exam is an important part of my eye exam and at this time I am declining the *doctor's recommendations* to obtain a comprehensive image of my retina. With the understanding that I will most likely be dilated today if the doctor feels he cannot view the entire health of my retina.