PATIENT DEMOGRAPHICS INFORMATION

PATIENT NAME:_____ TODAY'S DATE:_____

SSN:_____ DOB:_____ OCCUPATION:_____ SEX: Male Female

ADDRESS:_____ CITY:_____ ST:_____ ZIP:_____

HOME PHONE:_____ CELL PHONE:_____ PRIMARY CARE PROVIDER:_____

EMAIL:_____ HOW DID YOU HEAR ABOUT US?_____

INSURANCE INFORMATION

PRIMARY MEDICAL INS:_____ ID#_____

POLICY -HOLDER NAME:_____ DOB:_____ SS#_____

SECONDARY MEDICAL INS:_____ ID#_____

POLICY -HOLDER NAME:_____ DOB:_____ SS#_____

VISION INS. (GLASSES AND CONTACTS):_____ ID#/SS#_____ POLICYHOLDER NAME: _____

PATIENT ACKNOWLEDGEMENT

PRIVACY NOTICE-"I have read and understand the Notice of Privacy Practices for Medical Vision Institute, PSC and would like the following person(s) to have access to my account information: _____ (optional). I understand I can rescind this permission at any time with written notice to Medical Vision Institute."

INSURANCE PATIENTS-"I authorize my health insurance company to utilize my medical information as reasonably necessary for the proper administration of the health plan. I hereby assign MVI any payments of medical benefits for services rendered to myself or dependents." Copayments: MVI is required by your insurance to collect your copayment. Your copayment is due at the time of service. If you do not have your copayment, your appointment may be rescheduled. "I have read and understand that I am responsible for paying the annual deductible, copayment, coinsurance and any charges for non-covered services as determined by my insurance."

REFRACTION/CONTACT LENS FITTING FEE: "I have read the MVI fee schedule for refraction and contact lens fitting and understand these services may not be covered by my insurance plan. I understand if they are covered services, it would be under my vision plan, not medical insurance."

ACCEPTANCE OF FINANCIAL RESPONSIBILITY: "I acknowledge full financial responsibility for services rendered by MVI, regardless of insurance coverage and whether or not there was an accident with another party at fault."

OUTSTANDING BALANCES- "Any patients having an outstanding balance with a collection agency will not be able to make an appointment until the balance is paid in full. Any third party costs associated with collecting past due accounts will be added to the patient's account. MVI will charge 2% interest on any balances over 90 days old. I AGREE TO THE TERMS AND CONDITIONS ABOVE."

E-PRESCRIBING- "I have read the Medical Vision Institute (MVI) e-Prescribing consent form in its entirety and would like to enroll in the e-Prescribing program. I agree that Medical Vision Institute may request and use my prescription medication history from other healthcare providers or pharmacies for treatment purposes."

Responsible Party Signature: _____ (required)

For more information regarding MVI policies and procedures, please visit our website at www.medicalvision.com

OCULAR/MEDICAL HISTORY FORM

Name: Date of birth:

OCULAR HISTORY:(CIRCLE ALL THAT APPLY)	**MEDICAL HISTORY:(CIRCLE ALL THAT APPLY)**
PAST EYE INJURIES? NO / Details:	DIABETES / THYROID DISORDER / ARTHRITIS
PAST EYE SURGERY? NO / Details:	ANGINA / HYPERTENSION / HEART DISORDER
USED EYE DROPS? NO / Details:	ASTHMA / COPD / SLEEP APNEA
DO YOU WEAR GLASSES? NONE/ BIFOCALS / DISTANCE ONLY/ PRESCRIPTION READING/COMPUTER/CONTACT LENSES	ANY OTHER MEDICAL CONDITIONS:
PLEASE LIST DETAILS OF OTHER PAST SURGERIES OR HOSPITALIZATIONS:	
MEDICATIONS (PLEASE LIST) – And/or attach sheet 1. 2. 3. 4. 5. 6. 7. Primary Pharmacy: _____ Road Name: _____	**ALLERGIC REACTIONS (CIRCLE AND LIST)** ANESTHESIA, LATEX, IODINE, TAPE, EYE DROPS OTHER:
HAVE YOU HAD ANY MEDICAL TESTS RECENTLY? IF SO, WHAT FOR?	**HAVE YOU EXPERIENCED ANY OF THE FOLLOWING IN THE LAST YEAR?** (CIRCLE) Headache — Chest pain Anxiety/depression — Cancer Allergies — Change in bowel habit Shortness of breath — Weight loss/gain Uncontrolled blood sugar — Dry mouth

OCULAR/MEDICAL HISTORY FORM

Name: Date of birth:

HOW WOULD YOU DESCRIBE YOUR TOBACCO USE: (CIRCLE) Never smoker Former Smoker Current Smoker	**DOES ANYONE IN YOUR FAMILY HAVE A HISTORY OF EYE DISEASE?** e.g. glaucoma, macular degeneration
WHAT IS YOUR PROFESSION?	**PLEASE LIST A FEW OF YOUR HOBBIES/PASTIMES:**

Please indicate if you are experiencing the following symptoms:

Circle the number that corresponds to your answer.

	Always	Usually	Often	Seldom	Never
1. Eyes that are sensitive to light?	**4**	**3**	**2**	**1**	**0**
2. Eyes that feel gritty?	**4**	**3**	**2**	**1**	**0**
3. Painful or sore eyes?	**4**	**3**	**2**	**1**	**0**
4. Blurred vision?	**4**	**3**	**2**	**1**	**0**
5. Excess tearing?	**4**	**3**	**2**	**1**	**0**
6. Reduced side vision?	**4**	**3**	**2**	**1**	**0**
7. Double vision?	**4**	**3**	**2**	**1**	**0**
8. Glare/halos around lights?	**4**	**3**	**2**	**1**	**0**

Have problems with your eyes limited you in performing any of the following during the last week:

Circle the number that corresponds to your answer.

	Always	Usually	Often	Seldom	Never
1. Reading?	**4**	**3**	**2**	**1**	**0**
2. Driving at night?	**4**	**3**	**2**	**1**	**0**
3. Working on a computer?	**4**	**3**	**2**	**1**	**0**
4. Watching TV?	**4**	**3**	**2**	**1**	**0**
5. Seeing at night or in dim conditions?	**4**	**3**	**2**	**1**	**0**

Are there other concerns that you would like to address at this visit?

_____

_____

_____