

VISION CLINIC AT FOXHILL
2001 46TH AVE. GREELEY, CO 80634

DATE: _____

PATIENT INFORMATION											
Patient's last name:			First:		Middle:		<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Dr.	<input type="checkbox"/> Miss <input type="checkbox"/> 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: _____	
<input type="checkbox"/> Yes	<input type="checkbox"/> No				Weight: _____		/ /		<input type="checkbox"/> M	<input type="checkbox"/> 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				
<p>*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:</p> <p><input type="checkbox"/> I would like the Optomap Retinal Exam (Picture, No side effects, see bottom laminate page for more information)</p> <p><input type="checkbox"/> I would like Dilation (With drops, you will have blurry vision and light sensitivity and may require a driver)</p>											
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:			<input type="checkbox"/> Self	<input type="checkbox"/> Child	<input type="checkbox"/> Other	<input type="checkbox"/> 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

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

Family History

Condition	Relation to You	Condition	Relation to You
<input type="checkbox"/> Blindness		<input type="checkbox"/> High Blood Pressure	
<input type="checkbox"/> Cataract		<input type="checkbox"/> Arthritis	
<input type="checkbox"/> Glaucoma		<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Macular Degen.		<input type="checkbox"/> Heart Disease	
<input type="checkbox"/> Retinal Detachment		<input type="checkbox"/> 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
