Patient___________________________________DOB___/__/___Sex___Date__/__/___

Whom may we thank for your referral?____

Reason for visit____

Last Eye Exam? ________________ Doctor?_______________
Last Medical Exam?_____________ Doctor?_______________

Do you have any of the following eye related symptoms?
□ redness □ itchiness □ eye pain □ tearing □ light sensitivity
□ grittiness □ discharge □ dryness □ flashes/floaters

Do you currently wear:
□ Glasses How old is current pair?_________________________________
□ Contact lenses □ Soft □ Rigid What brand?___________________________

Are you interested in contact lenses today? □ Yes □ No Glasses? □ Yes □ No

Are you interested in information regarding Laser Vision Correction: □ Yes □ No

Occupation:________________________Hobbies:___________________________________

MEDICAL/SOCIAL HISTORY

Current Medications (including oral contraceptives, aspirin, vitamins):
____
____
Do you have any allergies to medications: Y /N If yes, please list:_______________________

Do you use: □ tobacco products Type/ Frequency: __________________________________
□ alcohol Type/ Frequency:__________________________________
□ recreational drugs Type/ Frequency:_____________________________________

Do/Does you or anyone in your family have/had the following conditions(M:maternal P:paternal)

CONDITION	NO	YES	RELATIONSHIP	CONDITION	NO	YES	RELATIONSHIP
Blindness	□	□	__________M/P	Arthritis	□	□	__________M/P
Cataract	□	□	__________M/P	Cancer	□	□	__________M/P
Crossed Eyes	□	□	__________M/P	Diabetes	□	□	__________M/P
Glaucoma	□	□	__________M/P	Heart Disease	□	□	__________M/P
Macular Degeneration	□	□	__________M/P	Kidney Disease	□	□	__________M/P
Retinal Detachment	□	□	__________M/P	Thyroid Disease	□	□	__________M/P
High Blood Pressure	□	□	__________M/P	Retinal Disease	□	□	__________M/P
Lupus	□	□	__________M/P	Other________	□	□	__________M/P

List all major injuries/surgeries/hospitalizations you have had: __________________________
____

Have you been exposed/infected with: □ HIV □Herpes □ Hepatitis

PATIENT REGISTRATION/INSURANCE INFORMATION

Name: ____ DOB _____/_____/__________

Address:____SS# ___-___-___ DL#_______

____Home Tel #:_________________

Employer:____Work Tel #:__________________

E-Mail: ____Mobile Tel #:_________________

VISION INSURANCE INFORMATION

Insured Member:______________________Relationship:____________ DOB____/____/___

S.S.#:______-____-______ Policy #:________________Employer:______________________

Address:_______________________________________Ins. Plan:______________________

_______________________________________Group #:________________________

ID#:____Authorization #:_________________

Patient status: □ Single □ Married □ Employed □ Student (FT) □ Student (PT)

Also Please Allow Us to Make a Copy of Your Medical Insurance Card

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I authorize payment of my medical benefits to the undersigned optometrists/supplier for services rendered. I understand that Cedar Park Vision Center will make every effort possible to bill my insurance and obtain the necessary information needed to bill my insurance. I also understand that if my insurance company fails to cover the services and materials, **I will be personally responsible for the services rendered.**

I understand that under the Health Insurance Portability and Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct vision services such as examinations, treatment and dispensing of eye glasses, contacts and other items pertinent to my eye care. I give my permission for my medical information to be discussed with the person(s) named here:

____

SIGNED:____DATE____________________

Undrstanding Your Contact Lens Care and Professional Fees

"What are contact lens professional fees for?" *As a contact lens wearer, additional tests are done for you that are necessary to make sure that your eyes are healthy, that your lenses fit properly, and to ensure that you are seeing as well as possible. Contact lens professional fees are for the extra testing and time taken by the staff and doctor each year to properly evaluate your contact lenses.*

"Isn't this part of my annual eye exam?" *There are additional contact lens-related test that are done in addition to the eye examination. These are procedures that only need to be done with contact lens wearers, not for the patients who do not wear contact lenses.*

"Doesn't my insurance cover contact lens professional fees?" *It depends on your plan's coverage. Most insurance plans cover a routine eye exam which determines your glasses prescription and evaluates your eye health. Contact lens services are separate procedures that are often not covered by insurance.*

"How much does it cost?" *Depending on the type of lenses that you wear, and your prescription needs, the cost ranges from $60-$120 annually. New contact lens wearers have an insertion and removal training fee of $15.*

I have read and understand the contact lens professional fees.

*Print name*___________________________ *Signature*_________________________

*Date*________________________