



WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we will be glad to help you.

PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____ First Name Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex M F Age _____ Birthdate _____

Married Widowed Single Minor

Separated Divorced Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____ SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? Yes No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

Please print name of Patient, Parent, Guardian or Personal Representative

Date

Relationship to Patient

PHONE NUMBERS

Home (_____) _____ Cell (_____) _____ Spouse's Work Phone (_____) _____ Ext _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

Home (_____) _____ Cell (_____) _____ Work Phone (_____) _____ Ext _____

EYE HEALTH HISTORY

Physician's Name _____

Date of last visit _____

Date of last eye exam _____

Name of doctor _____

Do you wear glasses? Yes No

All the time Occasionally
 Reading Driving TV

Do you wear contacts? Yes No

Type _____ Hours/Day _____

Describe any problems you have with your contacts _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Bloodshot Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Floaters or Spots	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blurred Vision – Distance	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blurred Vision – Near	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No
Burning Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Itching Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	Light Sensitive	<input type="checkbox"/> Yes <input type="checkbox"/> No
Color Vision, Poor	<input type="checkbox"/> Yes <input type="checkbox"/> No	Loss of Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No
Crossed Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Migraine Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No
Discharge from Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Night Vision, Poor	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dizzy Spells	<input type="checkbox"/> Yes <input type="checkbox"/> No	Red Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Double Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seeing Halos	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dry Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seeing Flashes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Eye Infection	<input type="checkbox"/> Yes <input type="checkbox"/> No	Temporary Loss of Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No
Eye Injury	<input type="checkbox"/> Yes <input type="checkbox"/> No	Twitching Eyelid	<input type="checkbox"/> Yes <input type="checkbox"/> No
Eye Strain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vision Poor	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fainting Spells, Blackouts	<input type="checkbox"/> Yes <input type="checkbox"/> No	Watering Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No

HEALTH HISTORY

Physician's Name _____ Date of last visit _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following. Also place a mark to indicate if a blood relative has had any of the following problems.

	Yourself	Family Members		Yourself	Family Members
AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis (Type _____)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valve	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lazy Eye	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lupus	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Migraine Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blindness	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Poor Color Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Retinal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shingles	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Drug Sensitivity	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin Conditions	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Conditions	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Eye Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Turned Eye	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hay Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you pregnant? _____	Number of children _____	
Heart Condition	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tobacco use _____	Alcohol use _____	

MEDICATIONS

List any medications you are currently taking, including eye drops:

Pharmacy Name _____

Phone (_____) _____

ALLERGIES

List your allergies to medications or other substances:

MEDICARE/MEDIGAP AUTHORIZATION

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to

_____ for any services furnished to me by that provider.
Name of Doctor or Clinic

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

_____ _____
Signature of Beneficiary, Guardian or Personal Representative Date

_____ _____
Please print name of Beneficiary, Guardian or Personal Representative Relationship to Beneficiary



Notice Of Privacy Practices

This Summary notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. We are legally obligated by law to keep your health information private and to give you notice of our privacy practices. This notice describes how we protect your health information and what rights you have regarding it.

Treatment, Payment, and Health Care Operations:

The most common reason we use or disclose your health information is for treatment, payment or health care operations. We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside our office for these reasons, we will ask you for written permission.

Uses and disclosures for other reasons without permission:

- When a state or federal law mandates such disclosure.
- For public health purposes dictated by federal Food and Drug Administration.
- Disclosure to government authorities concerning abuse, neglect or violence.
- Uses and disclosures for health care oversight regulatory activities.
- Disclosure for judicial and administrative proceedings.
- Disclosure for law enforcement purposes.
- Disclosure to a medical examiner for identification purposes.
- Uses or disclosure for health related research.
- Uses or disclosure for specialized government functions.
- Disclosure of de-identified information.
- Disclosure relating to worker's compensation programs.
- Disclosure of a "Limited Data Set" for research or health care operations.
- Disclosure to "Business associates" who perform health care operations for us.

List names of person or persons to whom you wish to release medical information.

Name _____ Phone # _____

Name _____ Phone # _____

Your rights regarding your health information:

The law protects your rights regarding your health information. You can:

- Ask us to restrict our uses and disclosures for purposes of treatment, payment or health care operations.
- Ask us to communicate with you in a confidential way.
- Receive copies of your health information.
- Ask us to amend your health information if you think it is incorrect or incomplete.
- Get a list of the disclosures that we have made of your health information.
- Get additional paper copies of this Notice of Privacy Practice upon request.

Acknowledgement of Receipt

I acknowledge that I have received a comprehensive copy of Advanced Vision of Louisville's Notice of Privacy Practices.

X _____ Date: ____/____/____

Patient, Parent or Legal Guardian Signature

Patient Financial Responsibilities

It is your responsibility to give our office current and up to date information. This includes name, address, and telephone number changes, as well as new insurance information.

It is your responsibility to know your Insurance Plan's policies and guidelines. Every Insurance Company is different. You should know if your insurance plan requires an authorization or a preferred provider in order for your services to be covered.

Save all explanation of benefits from your insurance company. These forms allow you to know why your insurance has paid or denied a service.

Collection Policies:

After your insurance has paid their portion the remaining balance becomes your responsibility. You will receive 2 monthly statements, if you fail to pay your bill or to make payment arrangements with us by the date listed on the second bill, your account will then be placed in our inner office collections. If you do not try to contact us or make a payment we will then turn it over to an outside collections agency. We do accept Visa, Master Card, American Express, and Care Credit.

_____	_____
Responsible Party	Responsible Party SS #
_____	_____
Self, Parent or Legal Guardian Signature	Responsible Party Address
_____	_____
Patient Name	
_____	_____
Patient Name	

Insurance Information

Primary	Secondary
Insurance Plan 1 _____	Insurance Plan 2 _____
Insured's Name _____	
Insured's ID # _____	
Insured's DOB _____	