



Visions Eye Care & Vision Therapy Center
Welcome To Our Office

Welcome to Visions Eye Care & Vision Therapy Center! Thank you for choosing us for your eye care needs. We are delighted to have you as a patient and appreciate the confidence you placed in us. Please take a moment to complete the following information. If you have any questions, please do not hesitate to ask.

Mr. Miss Mrs. Ms. Male Female

Form fields for personal information: First Name, MI, Last Name, Preferred Name, Street Address, City, State, Zip, Social Security Number, Date of Birth, Home Phone, Day Phone, Email Address, Guardian, Person Responsible for Account.

Form fields for demographic information: Race (American Indian, Asian, Black, Hispanic, etc.), Ethnicity, Preferred Language, Height, Weight.

Please Read:

In order to control the cost of billing, we ask that the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. We would rather control billing costs than be forced to raise our fees. All professional services and materials 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 are subject to collection fees. There will be a service charge on all returned checks.

Payment from my insurance is to be paid directly to Visions Eye Care & Vision Therapy Center. 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.

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA PRIVACY POLICIES: I acknowledge that I have received and/or been offered a copy of Visions Eye Care & Vision Therapy Center's Notice of Privacy Practices.

Signature and Date fields.

PATIENT HISTORY AND INFORMATION

DATE OF LAST EYE EXAM _____

EYE DISEASES (check those you have had)

- | | | |
|------------------------------------------|-----------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Amblyopia | <input type="checkbox"/> Diabetic Retinopathy | <input type="checkbox"/> High Risk Medication |
| <input type="checkbox"/> Blepharitis | <input type="checkbox"/> Dry Eye Syndrome | <input type="checkbox"/> Macular Degeneration |
| <input type="checkbox"/> Blindness | <input type="checkbox"/> Eye Injuries | <input type="checkbox"/> PVD |
| <input type="checkbox"/> Cataract(s) | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Retinal Detachment |
| <input type="checkbox"/> Color Blindness | <input type="checkbox"/> Glaucoma Suspect | <input type="checkbox"/> Strabismus |

CURRENT EYE SYMPTOMS (check those you are experiencing)

- | | | |
|-----------------------------------------------|---------------------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> Glare Sensitivity | <input type="checkbox"/> Foreign Body Sensation | <input type="checkbox"/> Distorted Vision (halos) |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Infection of Eye or Lid | <input type="checkbox"/> Double Vision |
| <input type="checkbox"/> Light Sensitivity | <input type="checkbox"/> Itching | <input type="checkbox"/> Flashes of Lights |
| <input type="checkbox"/> Tired Eyes | <input type="checkbox"/> Mucous | <input type="checkbox"/> Floaters or Spots |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Ptosis (Drooping Eyelid) | <input type="checkbox"/> Fluctuating Vision |
| <input type="checkbox"/> Dryness | <input type="checkbox"/> Redness | <input type="checkbox"/> Loss of Central Vision |
| <input type="checkbox"/> Excessive Tearing | <input type="checkbox"/> Sandy or Gritty Feeling | <input type="checkbox"/> Loss of Side Vision |
| <input type="checkbox"/> Eyelid Swelling | <input type="checkbox"/> Blurred Vision Distance | <input type="checkbox"/> Loss of Vision |
| <input type="checkbox"/> Eye Pain or Soreness | <input type="checkbox"/> Blurred Vision Near | <input type="checkbox"/> Other |

GENERAL HEALTH CONDITION (check those you have had)

- | | | |
|--------------------------------------------------------------------|------------------------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> Fever | <input type="checkbox"/> Respiratory (Asthma) | <input type="checkbox"/> Anxiety or Depression |
| <input type="checkbox"/> Unexplained Weight Loss | <input type="checkbox"/> Gastrointestinal | <input type="checkbox"/> Thyroid, Diabetes |
| <input type="checkbox"/> Other Symptoms | <input type="checkbox"/> Kidney | <input type="checkbox"/> Blood/Lymph |
| <input type="checkbox"/> Ears,Nose,Throat | <input type="checkbox"/> Muscles,Bones, Joints | <input type="checkbox"/> Allergic |
| <input type="checkbox"/> Cardiovascular (high blood pressure etc.) | <input type="checkbox"/> Skin | |
| | <input type="checkbox"/> Neurological (Multiple Sclerosis) | |

FEMALE HISTORY:

- Are you currently pregnant? Yes No
Are you currently nursing? Yes No

Primary Care Physician: _____

Major Illnesses: _____

Past Surgeries: _____

Current Medications: _____

Current Eye Drops: _____

Specific Allergies & Reactions: _____

FAMILY HISTORY (check those someone in your family has had & indicate relationship to you)

- | | | | |
|------------------------------------------------|-------|----------------------------------------------|-------|
| <input type="checkbox"/> Amblyopia (Lazy Eye) | _____ | <input type="checkbox"/> Cancer | _____ |
| <input type="checkbox"/> Blindness | _____ | <input type="checkbox"/> Diabetes | _____ |
| <input type="checkbox"/> Cataract(s) | _____ | <input type="checkbox"/> Heart Disease | _____ |
| <input type="checkbox"/> Color Blindness | _____ | <input type="checkbox"/> High Blood Pressure | _____ |
| <input type="checkbox"/> Glaucoma | _____ | <input type="checkbox"/> Kidney Disease | _____ |
| <input type="checkbox"/> Macular Degeneration | _____ | <input type="checkbox"/> Lupus | _____ |
| <input type="checkbox"/> Retinal Detachment | _____ | <input type="checkbox"/> Stroke | _____ |
| <input type="checkbox"/> Strabismus (Eye Turn) | _____ | <input type="checkbox"/> Thyroid Disease | _____ |
| <input type="checkbox"/> Arthritis | _____ | <input type="checkbox"/> Others | _____ |

PATIENT HISTORY AND INFORMATION

SOCIAL HISTORY

Employer/School: _____ Occupation/Grade: _____

Do you drink alcohol? No Occasional 1 per day 2-3/day 4+/day

Do you smoke? Never Smoker Current some day smoker
 Former Smoker Current every day smoker

SPECTACLE LENS HISTORY

Do you currently wear glasses? Yes No

Type Of Glasses: FullTime PartTime Distance Close

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

HOW WERE YOU REFERRED TO OUR OFFICE?

Phone Book School Advertisement Patient (Please Name) _____
 Insurance Listing Drive by Other _____ Doctor (Please Name) _____

DILATION AND VISUAL FIELD CONSENT

As your eye care professionals, Dr. Gulbranson, Dr. Hupke and Dr. Gentrup strongly recommend that all of our patients receive a dilated eye examination and visual field test as part of their comprehensive visual analysis.

The dilation and visual field test allow for a more thorough examination of the visual system. This will check for loss of sight in both the central and peripheral areas of vision and can also assist us in early detection of glaucoma, retinal problems, some neurological disorders (such as brain tumors and optic nerve disease), and enable us to better diagnose some possible causes of headaches.

Please check and sign below:

_____ I do consent to having my eyes dilated and a visual field test performed. (Visual field screening is \$20.00)

_____ I do not want my eyes dilated at this time. I do understand the importance of the dilation and visual field testing, yet I do not wish to have this performed at this time. I release Dr. Gulbranson, Dr. Hupke and Dr. Gentrup from any liability related to the failure to treat or diagnose any eye conditions due to the lack of diagnosis information, which could have been obtained by this test.

ABOUT YOUR INSURANCE

There are two types of health insurance that will help pay for your eye care services and products. You may have both and our practice accepts both:

1. Vision care plans (such as VSP and EyeMed)
2. Medical insurance (such as Blue Cross/Blue Shield and Medicare).
 - Vision care plans only cover routine vision exams along with eyeglasses and contact lenses. Vision plans only cover a basic screening for eye disease. They do not cover diagnosis, management or treatment of eye diseases.
 - Medical insurance must be used if you have any eye health problem or systemic health problem that has ocular complications. Your doctor will determine if these conditions apply to you, but some are determined by your case history.
 - If you have both types of insurance plans:
 1. Vision care plan guidelines dictate that medical insurance must be billed as primary if your medical insurance plan includes a routine eye exam.
 2. It may be necessary for us to bill some services to one plan and other services to the other. We will use coordination of benefits to do this properly and to minimize your out-of-pocket expense.
 - We will bill your insurance plan for services if we are a participating provider for that plan. We will try to obtain advanced authorization of your insurance benefits so we can tell you what is covered. If some fees are not paid by your plan, we will bill you for any unpaid deductibles, co-pays or non-covered services as allowed by the insurance contract.

I have read and agree with these policies.

Patient signature (parent if child)

Date