# TOTAL VISION CENTERS

**PATIENT INFORMATION**

DATE: ______ NEW PATIENT PREVIOUS PATIENT

NAME:

ADDRESS:

CITY/ST/ZIP:

HOME #: ______ WORK: ______ CELL:

BEST NUMBER TO REACH PT? ______ OK TO TXT? YES NO

EMAIL:

DATE OF BIRTH: ______ AGE: ______ MALE FEMALE

PT SS#: ______ MARITAL STATUS:

STUDENT: YES NO GRADE: ______ SCHOOL:

EMPLOYER: ______ OCCUPATION:

SPOUSE OR PARENT'S NAME:

SPOUSE OR PARENT'S EMPLOYER:

SPOUSE OR PARENT'S WORK NUMBER:

PHYSICIAN: ______ LAST VISIT:

PHARMACY: ______ LOCATION:

**VISION INFORMATION**

DATE OF LAST EXAM: ______ DR.:

DO YOU WEAR GLASSES? YES NO CONTACTS? YES NO

*IF NO, ARE YOU INTERESTED IN CONTACTS? YES NO

REASON FOR TODAY'S VISIT?

**INSURANCE INFORMATION:**

RESPONSIBLE PARTY: ______ RELATIONSHIP:

DATE OF BIRTH: ______ LAST 4 OF SS#:

VISION INSURANCE: ______ MEDICAL INS:

ID # ______ ID #

GROUP # ______ GROUP#

# MEDICAL INFO

## MEDICAL HISTORY

| | | |
|---|---|---|
| PREGNANT/NURSING (CURRENTLY) | YES | NO |
| ANXIETY | YES | NO |
| ARTHRITIS | YES | NO |
| ASTHMA | YES | NO |
| BONE MARROW TRANSPLANT | YES | NO |
| BPH (Enlarged Prostate) | YES | NO |
| BREAST CANCER | YES | NO |
| COLON CANCER | YES | NO |
| COPD (Chronic Obstructive Pulmonary) | YES | NO |
| CORONARY ARTERY DISEASE | YES | NO |
| DEPRESSION | YES | NO |
| DIABETES | YES | NO |
| GERD (Acid Reflux) | YES | NO |
| HEARING LOSS | YES | NO |
| HEPATITIS | YES | NO |
| HYPERTENSION (High Blood Pressure) | YES | NO |
| HIV/AIDS | YES | NO |
| HIGH CHOLESTOROL | YES | NO |
| HYPERTHYROIDISM (Over Active) | YES | NO |
| HYPOTHYROIDISM (Under Active) | YES | NO |
| LEUKEMIA | YES | NO |
| LUNG CANCER | YES | NO |
| LYMPHOMA (lymphatic cancer) | YES | NO |
| PROSTATE CANCER | YES | NO |
| RADIATION TREATMENT | YES | NO |
| SEIZURES | YES | NO |
| STROKE | YES | NO |

OTHER: ______________________

MAJOR SURGERIES: ______________________ DATE: ________

______________________ ________

## MEDICATIONS NONE

______________________

______________________

______________________

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## DRUG ALLERGIES NONE

______________________

______________________

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## FAMILY HISTORY

**if YES, please list relationship to patient

| | | |
|---|---|---|
| BLINDNESS | YES | NO |
| CANCER | YES | NO |
| CATARACTS | YES | NO |
| CVA (STROKE) | YES | NO |
| DIABETES | YES | NO |
| GLAUCOMA | YES | NO |
| HEART DISEASE | YES | NO |
| HYPERTENSION | YES | NO |
| MACULAR DEGENERATION | YES | NO |
| MIGRAINES | YES | NO |
| RETINAL DETACHMENT | YES | NO |
| STRABISMUS (Lazy Eye) | YES | NO |

OTHER______________________

## OCULAR HISTORY

| | | |
|---|---|---|
| BLEPHARITIS | YES | NO |
| CATARACTS | YES | NO |
| CORNEAL DYSTROPHY | YES | NO |
| DIABETIC RETINOPATHY | YES | NO |
| DRY EYES | YES | NO |
| GLAUCOMA | YES | NO |
| MACULAR DEGENERATION | YES | NO |
| OCULAR HYPERTENSION | YES | NO |
| OCULAR MIGRAINES | YES | NO |
| RETINAL TEAR | YES | NO |
| STRABISMUS | YES | NO |
| PVD | YES | NO |
| VITREOUS FLOATERS | YES | NO |

OTHER______________________

## OCULAR SURGERY

| | |
|---|---|
| CATARACTS | DATE: ________ |
| EYE MUSCLE | DATE: ________ |
| LASIK/PRK | DATE: ________ |
| RETINAL LASER | DATE: ________ |
| OTHER | DATE: ________ |

## SOCIAL HISTORY

| | | |
|---|---|---|
| DO YOU USE CIGARETTES OR TOBACCO PRODUCTS? | YES | NO |
| NUMBER OF PACKS PER DAY: ________ | | |
| DO YOU DRINK ALCOHOL? | YES | NO |
| ANY OTHER SUBSTANCES? | YES | NO |

## INSURANCE ASSIGNMENT AND RELEASE

I CERTIFY THAT I (OR MY DEPENDENT) HAVE INSURANCE COVERAGE WITH___________________________ AND ASSIGN DIRECTLY TO EITHER DR. DUBRO/DR. KUHN ALL INSURANCE BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR THE SERVICES RENDERED. ***I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE.*** I HEREBY AUTHORIZE THE DOCTOR TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS.

RESPONSIBLE PARTY SIGNATURE_______________________________________________

RELATIONSHIP TO PT IF OTHER THAN SELF _______________________ DATE:________________

## MEDICARE AUTHORIZATION
## **ONLY NEED TO SIGN IF YOU HAVE MEDICARE**

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO DR. DUBRO/DR. KUHN FOR ANY SERVICES FURNISHEDME BY THE DOCTOR. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENT ANY INFORMATION NEEEDED TO DETERMINE THOSE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES. I UNDERSTAND MY SIGNATURE REQUESTS THAT PAYMENT BE MADE AND AUTHORIZES RELEASE OF MEDICAL INFORMATION NECESSARY TO PAY THE CLAIM. IF " OTHER HEALTH INSURANCE" IS INDICATED IN ITEM 9 OF THE HCFA 1500 FORM, OR ELSEWHERE ON OTHER APPROVED CLAIM FORMS OR ELECTRONICALLY SUBMITTED CLAIMS, MY SIGNATURE AUTHORIZES RELEASING OF THE INFORMATION TO THE INSURER OR AGENCY SHOWN. IN MEDICARE ASSIGNED CASES, THE PHYSICIAN OR SUPPLIER AGREES TO ACCEPT THE CHARGE DETERMINATION OF THE MEDICARE CARRIER AS THE FULL CHARGE, AND THE PATIENT IS RESPOSIBLE ONLY FOR THE DEDUCTIBLE, COINSURANCE, AND NON COVERED SERVICES. COINSURANCE AND THE DEDUCTIBLE ARE BASED UPON THE CHARGE DETERMINATION OF THE MEDICARE CARRIER. REFRACTION IS NOT COVERED BY MEDICARE BENEFITS. AN ADDITIONAL CHARGE FOR THE REFRACTION WILL BE ASSESSED.

SIGNATURE OF BENEFICIARY________________________________ DATE:________________

## ACKNOWLEDGEMENT OF RECEIPT

I HAVE READ AND/OR RECEIVED A COPY OF **TOTAL VISION CENTERS** NOTICE OF PRIVACY PRACTICES (HIPAA)

PATIENT NAME:_______________________________________________ DATE:________________

SIGNATURE:_______________________ RELATIONSHIP TO PT IF NOT SELF: ______________________

## CANCELLATION POLICY

IF YOU NEED TO CANCEL OR RESCHEDULE YOUR APPOINTMENT, PLEASE GIVE A 24 HOUR NOTICE. IF YOU DO NOT GIVE A 24 HOUR NOTICE, WE RESERVE THE RIGHT TO REFUSE TO RESCHEDULE A NEW APPOINTMENT.

SIGNATURE: ____________________________________ DATE:________________