

SOUTHWEST VISION

Thank you for choosing our practice for your eye care needs. Please complete all pages of this form.
All information is confidential and allows for more complete analysis of your eye health and visual system.
If you have any questions or concerns, do not hesitate to ask for assistance.

TODAY'S DATE _____

PATIENT INFORMATION

Last Name _____ First Name _____

Address _____

City _____ State _____ Zip _____

Date of Birth _____ Age _____

Preferred Phone Number _____ (Circle One) Home Work Cell

Alternate Phone Number _____ (Circle One) Home Work Cell

Email Address _____

Emergency Contact Name _____ Phone _____

VISION (WELL CHECK) INSURANCE INFORMATION (Circle One)

VSP (Vision Service Plan) Superior Eye Med VCP (Vision Care Plan)

Other _____

Group # _____

Employer _____ Phone _____

Name of Insured _____ Relationship to Patient _____

Social Security/ID # _____ Date of Birth _____

HEALTH INSURANCE INFORMATION (Circle One)

Aetna Benefit Planners Blue Cross Blue Shield (BCBS) Cigna

Great West Guardian Humana PHCS Principal UnitedHealthcare (UHC)

Other _____

Group # _____

Employer _____ Phone _____

Name of Insured _____ Relationship to Patient _____

Social Security/ID # _____ Date of Birth _____

RESPONSIBILITY OF PAYMENT

I understand the coverage quoted to Southwest Vision by my vision and/or health insurance company is not a guarantee of payment.
Payment is based on eligibility and benefits at the time of service. I agree to pay any amount my insurance company denies or
indicates is patient responsibility.

Signature _____ Date _____

Date of Last Eye Exam _____ Last Eye Doctor _____

Reason for Today's Visit _____

Are you planning to get eyeglasses today? Y / N

If not a contact lens wearer, are you interested in trying contacts today? Y / N

Are you interested in learning more about Laser Vision Correction? Y / N

Contact Lens History:

Do you currently wear contacts? Y / N Hours per day: _____ Days per week: _____

Brand or prescription you are currently wearing? _____ Today's wearing time: _____

If not wearing contacts now, have you tried them in the past? Y / N Reason for stopping? _____

Glasses History:

Do you currently wear glasses? Y / N Part-time Full-time Distance Only Near Only

Glasses being worn now: (Circle One) Single Vision Bifocals Progressive Trifocals

Do you wear sunglasses? Y / N Are your sunglasses your most recent prescription? Y / N

Social History:

Employer: _____ Occupation: _____

Do you have any hobbies that require special glasses or contacts? _____

Use of Alcohol: None ___ Social use only ___ 1-2 drinks daily ___ Above average use ___ Alcohol Dependence ___

Use of Tobacco: None ___ Former Smoker ___ Light Smoker ___ Average Smoker ___ Heavy Smoker ___

Use of Narcotic: None ___ Type & Frequency _____

Current Medications

1. _____ for _____ 5. _____ for _____

2. _____ for _____ 6. _____ for _____

3. _____ for _____ 7. _____ for _____

4. _____ for _____ 8. _____ for _____

Drug Allergies Y / N Please list: _____

Ocular History

Please list all Ocular Surgeries:

Procedure: _____ Year: _____ Which Eye?: _____ Dr. _____

Procedure: _____ Year: _____ Which Eye?: _____ Dr. _____

Procedure: _____ Year: _____ Which Eye?: _____ Dr. _____

Family Physician:

Name _____ Address _____ Phone _____

Current Eye Symptoms/Conditions (Check All That Apply)

Headaches	Excess Tearing / Watering	Sandy / Gritty Feeling	Blurred Distance Vision
Glare / Light Sensitivity	Eye pain / Soreness	Foreign Body Sensation	Blurred Near Vision
Tired Eyes	Mucous Discharge	Burning	Fluctuating Vision
Dryness	Itching	Redness	Glaucoma
Floaters / Spots	Distorted Vision / Halos	Loss of Side Vision	Retinal Detachment
Macular Degeneration	Amblyopia / Lazy Eye		

Indicate Personal History Below (Check All That Apply)

Cardiovascular		Integumentary		Musculoskeletal	
Congestive Heart Failure		Acne Rosacea		Arthritis	
Elevated Cholesterol		Lupus		Rheumatoid Arthritis	
High Blood Pressure		Psoriasis			
Stroke					
Endocrine		Head / ENT / Dental		Neurological	
Diabetes		Chronic Cough		Bell's Palsy	
Gout		Migraines		Brain Tumor	
Thyroid (High or Low)		Sinusitis		Multiple Sclerosis	
Renal Disease (Kidney)		Dizziness		Parkinson's Disease	
				Seizures	
Gastrointestinal		Hematologic / Lymphatic		Psychiatric	
Cancer: Colon, Liver		Leukemia		Alzheimer's	
Colitis		Lymphatic Disorder		Bi-Polar Disorder	
Hepatitis		Sickle Cell Disease		Learning Disability	
Inflammatory Bowel Disease		Temporal Arthritis		Depression	
				Schizophrenia	
Genitourinary		Immunologic		Respiratory	
Menopause		Aids		Asthma	
Prostate Cancer		Sarcoidosis		COPD	
Cervical Cancer		Sjogren's Syndrome		Emphysema	
Breast Cancer		Syphilis		Lung Disorder	
		Tuberculosis		Lung Cancer	

Other _____

Family History

Relationship to Patient		Relationship to Patient	
Amblyopia / Lazy Eye		Cancer	
Blindness		Diabetes	
Cataracts		Heart Disease	
Glaucoma		Stroke	
Retinal Detachment		Thyroid Disease	
Macular Degeneration		Other :	

HIPAA PRIVACY

Acknowledgement of Receipt of Privacy Notice

By signing this acknowledgement of Receipt of Notice of Privacy Practices; I acknowledge and agree that I have received a copy of the Notice of Privacy Practices for review and to keep for my records on the date identified below.

I understand that Southwest Vision Center may use and disclose necessary personal health information (for example, my name, address, subscriber identification number, eye exam information and/or type of products provided) to another party to permit Southwest Vision Center to perform its administrative duties, provide me with eye care services and products, process my vision/medical benefit claims and communicate with me regarding vision care services provided by Southwest Vision Center (for example, mailings of exam reminders or information about services/products provided by Southwest Vision Center).

I can be assured that Southwest Vision Center does not sell my personal health information of any kind to a third party for such party's own use. I authorize Southwest Vision Center to submit my vision benefits claims to my plan sponsor or health plan to receive reimbursement directly for the vision/medical services and products that I have received from Southwest Vision Center.

Patient Signature or Patient's Legal Representative

Date