Welcome to Avon Vision Associates

DATE:_____

Last Name: _____ First: _____ MI: _____

DOB: _____ **SSN** (for insurance): _____ **Sex:** M / F

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ OK to text? Y / N Email: _____

Primary Care Physician: _____ Town: _____

Pharmacy: _____ Town: _____

EMERGENCY CONTACT: _____ Phone: _____

Eye History

Do you wear: Glasses / Contacts / Both Do you need to update contact lenses today? Y / N

Please check ALL that apply:

❑ Blurry vision	❑ Light sensitivity	❑ Headaches	❑ Redness	❑ Tearing	❑ Glare
❑ Dry or Gritty eyes	❑ Double vision	❑ Migraines	❑ Burning	❑ Flashes	❑ Tired eyes
❑ Mucus	❑ Droopy lids	❑ Eye pain	❑ Itching	❑ Floaters	❑ Other

Medical History

Any changes to your medical history since your last visit? _____

If you are ***diabetic***: A1C: _____ Fasted blood sugar: _____ **Pregnant?** Y / N **Breastfeeding?** Y / N

Authorization to Release Information

- I assign to Avon Vision Associates, all medical benefits, if any, otherwise payable to the provider for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance.
- I authorize Avon Vision Associates to release any information necessary to insurance carriers regarding my treatments, process insurance claims generated during my examination.
- I hereby authorize the doctor to release all information necessary to secure the payment of benefits.
- I authorize this signature to be used to process insurance claims for the period of my lifetime.
- I understand that carriers (vision plans and medical insurance) dictate which insurance is primary
- I understand I have the right to request a coordination of benefits between my medical carrier and Managed Vision Care Plan. I understand that this request is not a guarantee of payment through either plan and that my request may be denied dependent on the provisions of my medical and vision plans. Should my request be granted, I further understand that this coordination will exhaust my yearly benefits for both plans.
- I wish to authorize Avon Vision Associates to disclose my protected health information, including lab results and diagnoses, in messages left on my voicemail at the following number _____.
- I wish to authorize Avon Vision Associates to disclose my protected health information, including lab results and diagnoses, to the following person/s _____

By signing below, I am stating that I have thoroughly reviewed and understand Avon Vision Associates' Practice Policies. I agree to all that is stated within the practice policies and consent to receive services from Avon Vision Associates. I understand that this form is valid up to three years and is subject to change at which time I will be provided the revised form for review and signature.

I have received a copy or have read Avon Vision Associates' notice of Privacy and Practice Policies.

Printed Name: _____ Date: _____

Signature: _____ Relationship: _____