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: _____

Who Referred you? _____

Insurance Information *(Can leave blank if you have the cards with you)*

Medical Insurance: _____ Policy ID: _____ Group: _____

Policy Holder: _____ Relation: Self / Parent / Spouse DOB: _____

Vision Plan: _____ Policy ID: _____ Group: _____

Policy Holder: _____ Relation: Self / Parent / Spouse DOB: _____

Eye History

Do you wear: Glasses / Contacts / Both Last eye exam date/location: _____

Please check ALL that apply:

❑ Blurry vision	❑ Double vision	❑ Migraines	❑ Itching	❑ Glare
❑ Dry or Gritty eyes	❑ Crossed/Lazy eye	❑ Eye pain	❑ Tearing	❑ Tired Eyes
❑ Mucus	❑ Droopy lids	❑ Redness	❑ Flashes	❑ Other: _____
❑ Light sensitivity	❑ Headaches	❑ Burning	❑ Floaters	

Have you ever had surgery on your eyes or lids? Y / N _____

Other eye history: _____

Contact Lenses

Do you currently wear contact lenses? Y / N Are you interested in renewing contact lenses today? Y / N

What brand do you wear?: _____ Any complications? _____

Medical History

Have you been diagnosed with any of the following? Please check ALL that apply:

❑ Allergies	❑ Cholesterol	❑ HIV+ / AIDS	❑ Lyme Disease	❑ Stroke
❑ Anemia	❑ Chron's Disease	❑ Hypertension	❑ Psoriasis	❑ Thyroid
❑ Anxiety	❑ Depression	❑ Kidney disease	❑ Migraine	❑ Ulcerative Colitis
❑ Cancer	❑ Diabetes	❑ Leukemia	❑ MS	
❑ Cardiac disease	❑ Herpes	❑ Lupus	❑ Parkinson's	

Other: _____

Do you take any medication? Y / N Please list: _____

_____

Are you ***allergic*** to any medications: _____

If you are ***diabetic***: A1C: _____ Fasted blood sugar: _____

Pregnant? Y / N Breastfeeding? Y / N

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Family History

Does anyone in your family have any general health or eye problems? Please check ALL that apply: or Unknown

M - Mother F - Father S - Sibling GM - Grandmother GF - Grandfather A - Aunt U - Uncle

- ❑ Blindness _____
- ❑ Glaucoma_____
- ❑ Macular Degeneration_____
- ❑ Cataract_____
- ❑ Retinal Disease_____
- ❑ Cancer_____
- ❑ Diabetes_____
- ❑ Hypertension_____
- ❑ Heart Disease_____
- ❑ Lupus_____
- ❑ Stroke_____
- ❑ Thyroid_____

Social History

Employer: _____ Occupation: _____ Hobbies:_____

Do you drive? Y / N Do you drink? Y / N Do you currently use tobacco? Y / N Former smoker? Y / N

I agree that everything I have stated above pertaining to my health and personal history is accurate to the best of my knowledge.

Initials: _____

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: _____