

Welcome to West County Vision Center

Thank you for choosing our office for your eye care needs! Please take a moment to complete the following information. If you have any questions, please do not hesitate to ask.

First Name (Legal Name) MI Last Name Preferred Name

Street Address City State Zip Code

Home Phone Number Cell Phone Number Daytime Phone Number

Date of Birth Social Security Number Email Address

Emergency Contact Person Relationship to Patient Emergency Phone Number

Primary Care Physician Primary Care Physician Phone Number

Preferred Pharmacy Pharmacy Phone Number Pharmacy Location

Patient Status: ___ Male ___ Female ___ Single ___ Married ___ Other _____
 ___ Student ___ Employed ___ Retired ___ Unemployed ___ Other _____

Race:
___ Asian ___ African American ___ American Indian ___ Hispanic ___ White ___ Other ___ Decline to Specify

Ethnicity:
___ Asian ___ African American ___ Hispanic ___ Not Hispanic ___ White ___ Other ___ Decline to Specify

Vision Insurance Information:

Vision Insurance Company Member's First and Last Name Member's Date of Birth

Member's Social Security Number Employer Relationship to Member: ___ Self ___ Spouse
 ___ Child ___ Other

Medical Insurance Information:

Medical Insurance Company Member's First and Last Name Member's Date of Birth

Member Identification Number Employer Relationship to Member: ___ Self ___ Spouse
 ___ Child ___ Other

How were you referred to our office?

___ Website ___ Walk-in ___ Insurance Listing ___ Patient (Name) _____
___ Doctor (Name) _____ ___ Other _____

Patient Name _____

Health History:

Primary Care Physician and Practice Name _____

Address _____ Phone Number _____

What is the main reason for today's exam? _____ When was your last eye exam? _____ Are you interested in LASIK? _____

Previous and Current Eye Conditions: Please check all that apply

- | | | |
|---|--|--|
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Floaters or Spots | <input type="checkbox"/> Infection of Eye or Lid |
| <input type="checkbox"/> Dryness | <input type="checkbox"/> Drooping Eyelid(s) | <input type="checkbox"/> Sandy or Gritting Feeling |
| <input type="checkbox"/> Cataract(s) | <input type="checkbox"/> Fluctuating Vision | <input type="checkbox"/> Eye Pain or Soreness |
| <input type="checkbox"/> Redness | <input type="checkbox"/> Loss of Side Vision | <input type="checkbox"/> Excess Tearing/Watering |
| <input type="checkbox"/> Itching | <input type="checkbox"/> Mucous Discharge | <input type="checkbox"/> Foreign Body Sensation |
| <input type="checkbox"/> Tired Eyes | <input type="checkbox"/> Retinal Detachment | <input type="checkbox"/> Blurred Near Vision |
| <input type="checkbox"/> Loss Of Vision | <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Blurred Distance Vision |
| <input type="checkbox"/> Flashes of Light | <input type="checkbox"/> Glare/Light Sensitivity | <input type="checkbox"/> Distorted Vision (Halos) |
| <input type="checkbox"/> Color Blindness | <input type="checkbox"/> Amblyopia (Lazy Eye) | <input type="checkbox"/> Strabismus (Crossed Eyes) |
| <input type="checkbox"/> Double Vision | | |

Past Eye Surgery _____

General Health Conditions: Please check all that apply and explain

- | | | |
|---|---|--|
| <input type="checkbox"/> Fever | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Muscles | <input type="checkbox"/> Neurological _____ |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Bones | <input type="checkbox"/> Epilepsy _____ |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Joints | <input type="checkbox"/> Blood Disease(s) _____ |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Respiratory (Asthma) | <input type="checkbox"/> Skin _____ |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Gastrointestinal _____ |
| <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Ear, Nose, Throat _____ |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Cancer _____ |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Stroke | Are you Pregnant? _____ Are you Nursing? _____ |

Past Injuries: _____

Past Surgeries: _____

Family History: Please check all that apply

	Mom	Dad	Brother(s)	Sister(s)		Mom	Dad	Brother(s)	Sister(s)
Amblyopia (Lazy Eye)	___	___	___	___	Arthritis	___	___	___	___
Blindness	___	___	___	___	Cancer	___	___	___	___
Cataract(s)	___	___	___	___	Diabetes	___	___	___	___
Color Blindness	___	___	___	___	Heart Disease	___	___	___	___
Glaucoma	___	___	___	___	High Blood Pressure	___	___	___	___
Macular Degeneration	___	___	___	___	High Cholesterol	___	___	___	___
Retinal Detachment	___	___	___	___	Kidney Disease	___	___	___	___
Strabismus (Eye Turn)	___	___	___	___	Lupus	___	___	___	___
Other _____	___	___	___	___	Stroke	___	___	___	___
Other _____	___	___	___	___	Thyroid Disease	___	___	___	___

Current Medications and Dosage: _____

Current Eye Drop(s): _____

Medicines that cause reactions or sensitivities: _____

Specific Allergies (pollen, dust, etc.): _____

A Notice to Our Patients:

All copays and payments are required at the time of service. Any previous balances from insurance payments are due at time of visit. You may be asked for all balances and copays to be paid before you are seen by the doctor.

All of the frames and lenses are custom made in your particular prescription, therefore these items **CANNOT** be refunded. Once the order is placed no refund of any kind can be given. We will do everything in our power to ensure that you love your glasses and love wearing them.

Annual supplies of contact lens boxes that were purchased from our office that are unopened and unmarked can **ONLY** be exchanged for the same brand/type of contacts in a different power within one year of purchase.

Please do not hesitate to ask any member of our staff for clarification or if you have any questions.

I have read the above payment policy and understand that I am responsible for all payments as stated above.

Signature of Patient/Guardian

Print Name of Patient

Date

Authorization of release of Private Health Information (PHI) to person(s) other than patient

I, _____ would like the following person(s) to have access to my Private Health Information (PHI) upon their request:

_____ No one other than the patient will be allowed access to the patient's PHI

_____ Family members including (please include name and relationship to patient) and/or other individuals:

Name

Relationship

Name

Relationship

Name

Relationship

Signature

Date

(This document will remain valid until the patient sends request for change in writing to West County Vision Center)

Contact Lens Evaluation Fees

Dr. McReynolds prescribes high quality contact lenses to improve your vision and your lifestyle. Contact lenses are FDA regulated medical devices that can cause discomfort, infections, and even permanent vision loss if not cared for properly. New and existing contact lens wearers require additional time and testing during an eye examination to minimize the risk of serious eye problems. This additional testing is only done for contact lens wearers. Your contact lens evaluation and service fee includes:

- Specific curvature measurements of the cornea
- Evaluation of current and new lenses to insure optimal fit, vision, and comfort
- Medical assessment of the cornea, tear film, and conjunctiva as they relate to contact lens wear
- Instructions regarding safe contact lens wear, care, and proper solutions
- Contact lens follow up appointments for 60 days, after 60 days there will be an additional charge of \$30 for each additional visit

If you have any questions, please do not hesitate to speak with Dr. McReynolds.

Insurance Signature on File

Please Read and Sign Below:

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I authorize payment of these benefits directly to West County Vision Center on my behalf for any services and materials furnished. I authorize any holder of medical information about me to release to the Centers of Medicare Services and its agents, any information needed to determine these benefits payable to related services. If I have other health insurance coverage, my signature authorizes release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as my agent, as above.

I agree to pay all copays, deductibles, co-insurances, and non-covered services as determined by my insurance company. I understand verification of eligibility is **not a guarantee of payment** as stated by my insurance company. I understand that if the outstanding balance is not paid in full within 90 days of service date or purchase date of a product it will be sent to a collection agency. I understand that I will be responsible for both the amount of the balance and the amount charged by the collection agency.

If the patient is a minor child, I certify that I am the minor's legal guardian and have the legal right to authorize medical treatment (documentation may be required).

Signature of Patient/Legal Guardian

Date

HIPAA

I acknowledge that a copy of L. Michelle McReynolds, O.D. Notice of Privacy Practices has been made available to me.

Signature of Patient/Legal Guardian

Print Name

Date