SMITH VISION CENTER

PATIENT INFORMATION

Name:_____________________________________Nickname______________DOB_____/______/_________

Marital Status: (Married) (Single) (Divorced) (Widowed) Age:_____________ Sex: M / F

Social Security Number.__________-_________-_________ Email:_____________________________________

Address: ____ Apt # _______________

City: ____ State: ______________________ Zip: ______________

Home Phone: ( )__________-____________ Cell Phone: ( ) __________-____________

Emergency Contact: Name:____________________________ Phone: ( ) __________-____________

PERSON RESPONSIBLE FOR ACCOUNT:____

Relationship to patient: ____

VISUAL AND MEDICAL HISTORY

Reason for today's visit: ____

Date of last eye exam: _____/______/_________ By whom:___________________________________

Do you presently wear: Glasses Contacts Both Neither

How old are your glasses:_______________________ How old are your contacts:________________________

Name of Medical Doctor:_________________________ Phone number: ( ) _________-____________

Circle any of the following that you have ever been diagnosed with:

Cataract	Dry Eye
Age-Related Macular Degeneration	Eye Infection/Eye Allergy
Glaucoma	Floaters/Flashes of Light
Diabetes	Iritis/Uveitis
Diabetic Retinopathy	Retinal Defects or Degenerations

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REVIEW OF SYSTEMS

Do you currently, or have you ever had any problems in the following areas:

Constitutional

Cancer	Y	N
Fatigue Syndrome	Y	N

Ear, Nose, & Throat

Hearing Loss	Y	N
Sinusitis	Y	N
Dry Mouth	Y	N
Other:____________	Y	N

Neurological

Multiple Sclerosis	Y	N
Epilepsy	Y	N
Cerebral Palsy	Y	N
Brain Tumor	Y	N
Stroke/CVA	Y	N
Migraines	Y	N
Other:____________	Y	N

Psychiatric

Depression	Y	N
Attention Deficit Disorder	Y	N
Anxiety	Y	N
Bipolar Disorder	Y	N
Other:____________	Y	N

Cardiovascular

Hypertension	Y	N
Heart Disease	Y	N
Vascular Disease	Y	N
Congestive Heart Failure	Y	N

Respiratory

Asthma	Y	N
Bronchitis	Y	N
Emphysema	Y	N
COPD	Y	N
Sleep Apnea	Y	N
Other:____________	Y	N

Gastrointestinal

Crohn's	Y	N
Colitis	Y	N
Ulcer	Y	N
Acid Reflux	Y	N
Celiac Disease	Y	N

Genitourinary

Kidney Disease	Y	N
Prostate Disease/Cancer	Y	N

Musculoskeletal

Arthritis	Y	N
Fibromyalgia	Y	N
Gout	Y	N
Other:____________	Y	N

Integumentary

Eczema	Y	N
Rosacea	Y	N
Psoriasis	Y	N
Herpes Simplex (Cold Sores)	Y	N
Herpes Zoster (Shingles)	Y	N

Endocrine

Type 1 Diabetes	Y	N
Type 2 Diabetes	Y	N
Thyroid Dysfunction	Y	N
Hormonal Dysfunction	Y	N

Hematologic/Lymphatic

Anemia	Y	N
High Cholesterol	Y	N

Allergic/Immunologic

Drug Allergies	Y	N
Environmental Allergies	Y	N
Lupus	Y	N
Sarcoidosis	Y	N

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Are you currently taking any medications (including birth control, aspirin, OTC, and herbal) Please list below:

______________________________ ______________________________ ______________________________

______________________________ ______________________________ ______________________________

______________________________ ______________________________ ______________________________

______________________________ ______________________________ ______________________________

Do you have allergies to any medication YES NO

If yes please list: ____

Do you have any other allergies (Latex, Bee Stings, Food, etc.) YES NO

If yes please list: ____

SOCIAL HISTORY

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

Smoking Status: Previous Never Current

If you currently or previously used tobacco what type/amount/length: ___________________________________

Do you currently or previously use illegal drugs: Y / N Type/amount/length __________________________

Have you ever been exposed to or infected with: Gonorrhea Hepatitis HIV Syphilis

FAMILY MEDICAL/OCULAR HISTORY

Please note any family history (Parents, Grandparents, Children, Siblings) for the following:

Diabetes	Y / N	_________________	Cataract	Y / N	________________
Heart Disease	Y / N	_________________	Glaucoma	Y / N	________________
High Blood Pressure	Y / N	_________________	Macular Degeneration	Y / N	________________
Kidney Disease	Y / N	_________________	Retinal Detachment	Y / N	________________
Thyroid Disease	Y / N	_________________	Lazy/Crossed Eye	Y / N	________________
Cancer	Y / N	_________________	Blindness	Y / N	________________

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Regarding Insurance: We will do all that we can to find out what your insurance benefits are, and what you are eligible for. We will also submit your claim for you. The information given to us by your insurance company is not a guarantee of payment from them. If the insurance company does not pay this amount it will be your responsibility to pay your balance.
We cannot bill your insurance company unless you give us your current insurance information. Your insurance policy is a contract between you and your insurance company; we are not a party to that contract. It is your responsibility to provide your insurance company with the correct information at all times and to be aware of your policy's benefits. Please be aware that some, and perhaps all, of the services provided may be non-covered services.
If you do not present us with your insurance information at the time of service we reserve the right to bill the patient and have the patient submit the claim to insurance on their own.

Our Financial policy: Thank you for choosing us as your vision care provider. We are committed to your treatment being successful. All patients must complete our insurance and personal information forms before seeing the doctor. Payments for professional services and co-payments are due upon completion of the examination. Complete payment is due when any materials are received. All custom material purchases are nonreturnable/nonrefundable. There is a $30 return check charge on all returned checks. Any account not paid in full after 90 days from date of service becomes the patients' responsibility regardless of the patients' insurance coverage.
For charges not covered by your insurance, we will send out monthly statements. If you fail to pay the charges incurred and your account is turned over to collections, you agree to pay all costs of collection including, but not limited to, all court costs and reasonable attorney's fees for in the amount of 33% of the outstanding debt as customarily charged in the area for collection, or as otherwise determined reasonable by the court.

Authorization: I hereby authorize payment of my medical and vision benefits to Christopher A. Smith O.D., P.A., DBA Smith Vision Center. I understand that I am financially responsible for any charges whether or not paid by said insurance. If my insurance company or health plan designated co-payments and/or deductibles, I agree to pay them to Christopher A. Smith O.D., P.A., DBA Smith Vision Center at the time of service. I authorize Christopher A. Smith O.D., P.A., DBA Smith Vision Center to release any information required to process any and all claims for reimbursement on my behalf. A copy of this authorization may be used in place of the original.

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Signature of patient or guardian Date

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I the Patient/Guardian/Responsible Party have accurately and truthfully completed the information listed on the form. I agree that all fees incurred are my responsibility regardless of insurance coverage. I acknowledge that I have received a “Notice of Privacy Practices” regarding the use and disclosure of my health information.

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Signature of patient or guardian   Date