

Welcome Back!

We appreciate your returning to our office for your continued eyecare needs. We will strive to provide you with the best possible care. To help us meet your needs, please fill out this form completely. If you have any questions or need assistance, please ask us--we will be happy to help!

Name _____
Address _____
Phone _____

Date _____
Occupation _____
Employer _____
Work Phone _____

E-Mail Address _____ Social Security No. _____

Would you prefer to receive communication from us by e-mail? Yes No

If student: Grade Level _____ School _____

Other family members (living at home):

Name: _____ Relation: _____ Age: _____ Our Patient? _____

Who is responsible for payment? _____

Are any family members in need of eyecare? _____

PLEASE NOTE OUR OFFICE FINANCIAL POLICY:

Professional fees for services are due upon completion of the examination or treatment; we accept assignment on Medicare and a few insurance plans. For glasses, contacts, or other materials ordered custom-made for a patient, at least 50% downpayment must be made before ordering. *Payment plans are available; please ask any staff member for details.* Please check your preferred method of payment:

Cash ___ Check ___ Credit Card ___ Payment Plan ___

Please inform us of any changes in your INSURANCE or VISION PLANS before your exam!

We will be glad to file any claims for you and help you in any way to obtain your benefits!

***Do you participate in a flexible spending plan, flexible benefits plan, or medical savings account through your employer?
(Eyecare is generally reimbursable through these plans.) Yes No

AGREEMENT FOR THE PURCHASE OF PROFESSIONAL SERVICES AND MATERIALS: I assume responsibility for my bill at Vision Health Care, Inc. I understand the financial policy above. Any unpaid balance after services are rendered will have a billing fee applied each month. If I fail to make any payment on my debt made under this agreement when due, I also agree and promise to pay all reasonable collection fees, including but not limited to attorney's fees, court costs and interest. In this connection the laws of the State of West Virginia shall govern this agreement. The Magistrate Court or Circuit Court of Marion County, West Virginia, shall have jurisdiction over any dispute that arises under this agreement, and each of the parties shall submit and now consents to this court's jurisdiction.

Signature _____ (If under 18, parent must sign)

INSURANCE AUTHORIZATION: I authorize the release of all information necessary to determine all medical benefits, including major medical, Medicare, Medicaid, and other health and vision plans, to process such claims, and to authorize payment of medical benefits to: Vision Health Care, Inc., Dr. Cheryl C. Van Horn, at 717 Fairmont Avenue, Fairmont, WV 26554. This assignment and authorization is in effect until I choose to revoke it in writing, however, any such revocation shall have no effect on other provisions of this agreement.

Signature _____ (If under 18, parent must sign)

Thank You for your Help!
Dr. Van Horn, Dr. Kendall, and Staff

When was your last eye exam? _____ By Whom? _____

Main current problem you are having with your eyes or vision? _____

Main problems with your current glasses or contact lenses? _____

Do you wear glasses?

YES: *full-time* *for reading only* *for distance only* *other* _____

How old are your current glasses? _____

How old are your spare pair of prescription eyewear? _____

What would you like to change about your current glasses? _____

NO: *never worn* *no longer worn* since _____ because _____

Do you wear contact lenses?

YES: *currently wear* (type _____) What would you like to change about your contacts? _____

NO: *never worn* *previously worn* (type _____)

Are there times that you would rather not wear your glasses? When? _____

Are you interested in a free trial with contact lenses? YES NO

Are you interested in learning more about laser vision correction (refractive surgery)? YES NO

Do you have sunglasses filtering 100% of UV rays? YES-- prescription non-prescription NO NOT SURE
polarized non-polarized not sure

Does your job require safety glasses be worn? YES NO

Are you currently having frequent problems with any of the following:

blurry distance vision (driving, television, board in school, night vision, other)

blurry near vision (general reading, phone books, sewing & crafts, work tasks, other)

burning tiring/fatigue watering/tearing floaters/spots/specks

itching aching/deep pain matter/mucous light flashes or flickers

blurring headaches dryness double vision

redness strained feeling gritty sensation distortion/waviness

glare learning problems blurred night vision other problems: _____

eyes sensitive to sunlight eyes sensitive to indoor/fluorescent lighting

uncomfortable glasses uncomfortable contact lenses

Have you ever had any vision training, patching for lazy eye, or other eye therapy? Please explain. _____

What hobbies and activities are you involved in on a regular basis?

extended reading or paperwork for: work pleasure

computer use--average time spent most days: work—for _____ hrs/day home—for _____ hrs/day

frequent television viewing frequent movies/theater/concerts

sports active participant in: spectator/fan! soccer baseball basketball skiing

football golf tennis/racquetball bowling hockey

hunting/shooting running/jogging skating bicycling other__

water sports: swimming/diving water-skiing boating

scuba/snorkeling fishing other _____

other outdoor activities: job-related yard work/gardening hiking camping other _____

frequent driving for: work pleasure ---How Much? Daytime driving for _____ hrs/week & Nighttime for _____ hrs/wk

music: listening singing instrument _____

crafts/sewing---specifically: _____

home repair & maintenance

automobile repair & maintenance

woodwork grinding welding

other _____

Patient Signature _____

Date _____

Tech _____ Doctor _____