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_____ Date_____
Address_____ Occupation_____
_____ Employer_____
Phone_____ 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_____