Welcome to Our Office!

Thank you for selecting our office to provide your eyecare. 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 #___________________________

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?*____

Do you have any family members in need of eyecare? ______________________________

We always like to give a special thanks to anyone who recommends our services. Did someone refer you to us?

Family ___ Friend ___ Doctor ___ NAME_____________________

Or did you come here because of:

Location ___ Insurance/Vision Plan ___ Phone Book ___ Advertisement___

Civic Group or Community Event___ Vision Screening___ Other____________

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 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!!

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	snow skiing
	football	golf	tennis/racquetball	bowling	hunting/shooting
	hockey	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___________________