Vision Care Medical Group

PATIENT DEMOGRAPHICS FORM

DEMOGRAPHICS:

Acct# _____

DATE: _____.

First Name: _____ **M.I.:** _____ **Last Name:** _____

How did you hear about us?: ❑ Healthcare Provider ❑ Google-Web ❑ Insurance
❑ **Friend/Family**: _____ ❑ Other: _____

DOB: _____ **Age:** _____ **SS #:** _____

Address: _____
(street) (town/city) (state) (zip code)

Cell Phone: _____ **Alternate Phone:** _____ **Work Phone:** _____

Email: _____ **Preferred Method of Contact:** ❑ Phone ❑ Text ❑ Email

Birth Sex: ❑ Male ❑ Female **Preferred Gender:** _____

Preferred Pronouns: ❑ He/Him ❑ She/Her ❑ Other: _____

Race: ❑ American Indian or Alaska Native ❑ Asian ❑ Black or African American
❑ Caucasian ❑ Hispanic ❑ Other

Ethnicity: ❑ Non-Hispanic ❑ Hispanic/Latino ❑ Other

Primary Language Spoken: _____ **Do you need a translator?** ❑ Yes ❑ No

Relationship Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced

Spouse Name: _____ **Date of Birth:** _____ Cell# _____.

INSURANCE:

Is a referral required for this visit? ❑ Yes ❑ No **Name of referring doctor:** _____

Primary Medical Insurance:

Insurance Co: _____ Policy #: _____ Group #: _____
Subscriber's Name: _____ SS#: _____ DOB: _____
Relationship to Patient: _____ Phone: _____

Secondary Medical Insurance:

Insurance Co: _____ Policy #: _____ Group #: _____
Subscriber's Name: _____ SS#: _____ DOB: _____
Relationship to Patient: _____ Phone: _____

Vision Insurance:

Insurance Co: _____ Policy #: _____
Subscriber's Name: _____ SS#: _____ DOB: _____
Relationship to Patient: _____ Phone: _____

*There is a $25 fee for resubmission on any claim due to incorrect information given on date of service.

MEDICAL INFORMATION AUTHORIZATION

- **I authorize payment of all insurance benefits for services rendered for this office made payable to "Vision Care Medical Group- Kathleen J. Dennis-Zarate M.D.,A Medical Corporation"**
- I **hereby authorize** Vision Care Medical Group to release any information required by my insurance carrier to process any claim for payment. I *acknowledge that I am responsible for all non-covered charges.*
- **All co-pays and fees not covered by insurance are payable at time of service and am Liable for incurred charges for Ophthalmology services.**
- If you belong in a Managed Care insurance plan and need a referral, it is your responsibility to obtain one for your appointment. If you do not have a referral, you are required to pay in full for services rendered at time of service.
- I acknowledge that I have the option of receiving a copy of Vision Care Medical Group Privacy Practices which includes the new HIPAA Privacy Practices.
- I have read and acknowledge the Vision Care Medical Group notice of Medical and Vision Insurance Billing.

In order to discuss or disclose any medical information, we must have a signed consent on file allowing Vision Care Medical Group to share information about your care at our office. This information can be changed or revoked at any time with your permission.

Release of Medical Information:

I authorize Vision Care Medical Group to share information related to my health status* to the individual(s) listed below.

❑ I decline to have my medical information discussed with any party*.

*I understand this might include such information as: diagnosis, prognosis, treatment plans and medications, test results, appointment reminders, medical billing, insurance, and any other medical information relevant to my care.

Please list the names of those you would like to involve in your health care.

Authorized Individuals:

_____ Relationship to Patient: _____
(Name)

_____ Relationship to Patient: _____
(Name)

_____ Relationship to Patient: _____
(Name)

Please sign below to acknowledge that you have read and understand the above information:

Patient's Name: _____ **Date of Birth:** _____

_____ Date: _____

(***Patient/Guarantor Signature*** ↑)

_____ Date: _____

(Parent/Guardian Signature if under 18 years old↑)

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Vision Care Medical Group

PATIENT HISTORY FORM

Date:_____

Name: _____ **DOB:** _____ **Age:** _____

Employment Status: ❑ **Employed** ❑ **Unemployed** ❑ **Retired** ❑ **Student** ❑ **Active Military**

Occupation: _____ **Employer:** _____ **Hobbies:** _____

Last eye exam: _____ **Pharmacy Name:** _____.

- **Primary Care Physician:** _____ **Last PCP Visit:** _____

Do you wear: ❑ None ❑ Glasses ❑ Contact Lenses: _____
(Contact Lens Brand)

- **Purpose of today's visit (please check all that apply):**

❑ Blurry Vision ❑ Headaches ❑ Eye pain ❑ Double vision ❑ Glare
❑ Difficulty with night vision ❑ Focusing issues ❑ Loss of vision ❑ Floaters ❑ Flashes of light
❑ Burning ❑ Itchiness ❑ Redness ❑ Watery eyes ❑ Dryness
❑ Other: _____

- **Have you ever been diagnosed with or previously had any of the following eye conditions?** ❑ None

❑ Corneal Abrasion ❑ Corneal Ulcer ❑ Uveitis ❑ Glaucoma ❑ Diabetic Retinopathy
❑ Lazy Eye/Amblyopia ❑ Dry Eye ❑ Eye injury ❑ Retinal Hole/Tear ❑ Macular Degeneration
❑ Eye Turn/Strabismus ❑ Eye infection ❑ Cataracts ❑ Retinal Detachment ❑ Blindness
❑ Other eye diseases: _____

- **History of eye surgery?:** ❑ No ❑ Yes: _____
- **Vision Correction Surgery**: ❑ No ❑ Yes type: ❑ Lasik ❑ PRK ❑ Other _____ When: _____
- **Do you see an ophthalmologist/eye specialist?** ❑ No ❑ Yes: _____
- **Do you have any other specialists?:** ❑ No ❑ Yes: _____
- **Are you currently pregnant or nursing?** ❑ N/A ❑ No ❑ Yes
- **Do you drink alcohol?** ❑ No ❑ Yes **Do you use recreational drugs?** ❑ No ❑ Yes
- **Do you smoke?** ❑ Never ❑ Former Smoker ❑ Current smoker: **How often?** _____

- **Have you ever been diagnosed or treated for any of the following health problems?** ❑ None

❑ Allergies ❑ Anxiety Disorder ❑ Arthritis ❑ Asthma ❑ Autoimmune ❑ Cancer ❑ Concussion
❑ COPD ❑ Crohn's ❑ Depression ❑ Diabetes ❑ GERD ❑ Heart Disease/CHF
❑ High blood pressure ❑ High cholesterol ❑ Kidney disease ❑ Migraines ❑ Ulcerative Colitis
❑ Reproductive/STD ❑ Seizures ❑ Sinus ❑ Stroke ❑ Thyroid disease ❑ Vertigo

- **Please list all medications and over the counter supplements you currently take:** ❑ None

_____

_____

_____

- **Medication allergies:** ❑ None ❑ Yes: _____
- **Please list any prior surgeries and approximate dates:** _____

_____

- **Has anyone in your family ever been diagnosed with any of the following conditions?** ❑ None

❑ Blindness ❑ Eye Turn/Strabismus ❑ Lazy Eye/Amblyopia ❑ Keratoconus ❑ Cataracts ❑ Glaucoma
❑ Macular Degeneration ❑ Retinal Detachment ❑ Cancer ❑ Diabetes ❑ Heart Disease ❑ Thyroid disease