visionplus
for vision. for health. for life.

WELCOME TO OUR OFFICE

Patient Information

Today's Date __________________

Last ____
First _____________________________ MI _______
Street _______________________________________
City ____________________________ State _______
Zip Code ____________________________________
Home Phone _________________________________
Work Phone __________________________________
Date of Birth ____________________Age _________
Sex M F
Email _______________________________________

Employer (or School) __________________________
Occupation (or Grade) _________________________
Spouse (or Parent's Name) _____________________
Spouse (or Parent's Work) _____________________

What is the main purpose of today's visit?
____
____
____

NEW PATIENTS ONLY:
Is there someone we can thank for referring you to our office? ______________________________________

If not referred, how did you choose our office?
- ❑ Physician ________________________________
- ❑ Insurance List
- ❑ Saw Sign/Building
- ❑ Newspaper/Radio/TV
- ❑ Yellow Pages: Which directory? ______________
- ❑ Web Page: Which Web Site? ________________
- ❑ Other ____________________________________

The mission of Vision Plus is to contribute to a lifetime of healthy vision, providing each patient with the highest quality vision care and consequent quality of life. We will seek continuing education to remain at the forefront of our profession and will offer the latest eye care technology, professional services, and products. The visual needs and wellness of each patient will always be our first priority. Everything we do will communicate this.

Insurance Information

Primary Medical Insurance________________________
Subscriber Name_____________________________
Subscriber ID/Last 4 SSN_______________________
Subscriber Birth Date__________________________

Vision Insurance______________________________
Subscriber Name_____________________________
Subscriber ID/Last 4 SSN_______________________
Subscriber Birth Date__________________________

Do you intend to use a flex spending account (FSA) or HSA today? ❑ Yes ❑ No
How will you settle your account today?
❑ Cash ❑ Check ❑ Credit Card
Payment Plans Available! Ask about ***CareCredit*.**

Lifestyle Questions

Do you……(check box if your answer is yes)
- ❑..work at a computer?
- ❑..think you might benefit from thinner, lighter lenses?
- ❑..have interest in a "test drive" of the latest contact lens designs?
- ❑..spend time outdoors? How much? ___hrs/week
- ❑..have prescription sunwear?
- ❑..prefer not to wear your glasses at times?
- ❑..want to discuss Laser Vision Correction surgery?
- ❑..have more than 1 pair of current Rx eyewear?
- ❑..have children?
- ❑..have family members in need of eyecare?

Have you ever experienced, been diagnosed or treated for any of the following?
- ❑ Eye Allergies
- ❑ Blurry Vision
- ❑ Cataracts
- ❑ Crossed eye/Eye turn
- ❑ Eye Infections
- ❑ Flash of light
- ❑ Glaucoma
- ❑ Headaches
- ❑ Itchiness
- ❑ Macular Degeneration
- ❑ Retinal Detachment
- ❑ Tearing
- ❑ Uncomfortable glasses
- ❑ Other eye disorders_____________________________
- ❑ Eye Dryness
- ❑ Burning
- ❑ Corneal Abrasions
- ❑ Double Vision
- ❑ Eye Injury
- ❑ Floaters/Spots
- ❑ Grittiness
- ❑ Iritis/Uveitis
- ❑ Lazy Eye
- ❑ Occasional dryness
- ❑ Sunlight Sensitivity
- ❑ Trouble seeing at night

The information in this confidential case history form is critical to the evaluation of your vision and health.

Patient Medical History

Name of Family Physician__________________________
Date of Last Physical/Check-up______________________

CURRENT MEDICATIONS (Rx or Over the Counter)
(List name of medications including eye drops, vitamins, & birth control pills)________________________________
____
____

Allergies to medications? ☐ Yes ☐ No
If so, what medications? ____________________________
____

Do you smoke? ☐ Yes ☐ No
Do you drink alcohol? ☐ Yes ☐ No
Do you use other substances? ☐ Yes ☐ No

Have you ever been diagnosed or treated for the following health problems?	**Yes**	**No**
Allergies	☐	☐
Rheumatoid Arthritis	☐	☐
Blurred Vision	☐	☐
Double Vision	☐	☐
Fibromyalgia	☐	☐
Osteoarthritis	☐	☐
Heart Disease	☐	☐
Hypertension	☐	☐
Stroke	☐	☐
Crohn's Disease	☐	☐
Ulcers	☐	☐
Multiple Sclerosis	☐	☐
Epilepsy	☐	☐
Fatigue	☐	☐
Trauma	☐	☐
STD	☐	☐
Depression	☐	☐
Panic Disorder	☐	☐
Sore Throat	☐	☐
Leukemia	☐	☐
Asthma	☐	☐
Emphysema	☐	☐
Diabetes	☐	☐
Thyroid Dysfunction	☐	☐
Rosacea	☐	☐

Other: ____

(Women) Are you pregnant? ☐ Yes ☐ No

Patient Vision History

Date of Last Eye Exam____________________________
By Whom?_____________________________________

Do you have problems with any of your current glasses?
____
____

Do you currently wear contact lenses? ☐ Yes ☐ No
What kind?____________________________________
Solutions used__________________________________
Are you satisfied with the vision and comfort of your contact lenses? ☐ Yes ☐ No
Any interest in color or bifocal contact lenses?
☐ Yes ☐ No

If not already wearing, would you like to try contact lenses? ☐ Yes ☐ No

Is there a family medical history of any of the following:
(Please check boxes)

		(Mother's or Father's side)
Blindness	☐	________________
Cataracts	☐	________________
Corneal Problems	☐	________________
Diabetes	☐	________________
Glaucoma	☐	________________
Heart Disease	☐	________________
Lazy Eye	☐	________________
Macular Degeneration	☐	________________
Retinal Problems	☐	________________

Other: ______________________________________

Family Medical/Eye History

Acknowledgement of Receipt of Notice of Privacy Practices

I, the patient, have received a copy of this office's Notice of Privacy Practices (HIPAA).

Print name: ______________________________

Sign name: ______________________________

Date: ______________________________

Financial Responsibility

We will be happy to file your medical or vision insurance claims. We will do all we can to help you receive maximum benefits. However, in the event that the plan sponsor determines you are not eligible for coverage at the time of service, or makes a determination that you are eligible for a reduced level of coverage, by signing this statement you hereby agree to be financially responsible for any and all charges incurred by you and not paid by the plan sponsor.

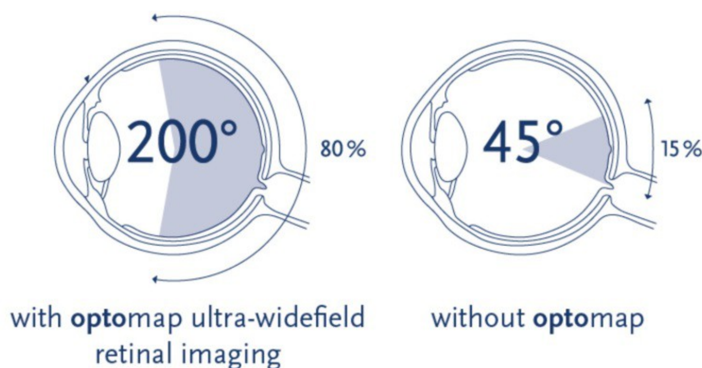
Sign name and date: ____

Optomap Retinal Screening

We pride ourselves on providing our patients with the best possible standard of care.

Dr. Korsgarden strongly recommends this yearly for all of his patients.

What it is: A retinal photo that gives the doctor a very wide view of the back of the eye. Having a photo gives the doctor the ability to compare photos each year. This can often replace dilation or be done in addition to it for those that require it.



Why is it important: Many diseases have no initial symptoms. Retinal problems (macular degeneration, glaucoma, retinal detachments, diabetic retinopathy) require early diagnosis for the best outcome. This test can also help detect other diseases such as heart disease, a stroke, hypertension and diabetes.

The fee for this test is $29.00. Many offices charge up to $100.00 for similar retinal photos. Dr. Korsgarden has greatly reduced the fee to make it accessible to all because he wants as many patients as possible to benefit from this technology.

_____ YES, I would like the Optomap® today.

_____ Unsure, I would like more information from the doctor.

I have read and understand this document:

Sign: ____ Date: ___________________

Return Policy and Warranty

Our team is enthusiastic about providing you with great eye care, and finding the right eyewear for your lifestyle. In order to continue providing you the latest styles at truly competitive prices, we do not accept any returns on frames, prescription lenses, and contacts once you have placed your order. We want to make sure that your eyewear purchase works and benefits you. If there is any problem with the prescription, you have **60 days** from the purchase date to return for a one-time remake to correct the issues with your prescription. If you originally saw our doctor for the current prescription, this visit is free of charge. If you saw an outside doctor, please return with the corrected prescription from your doctor and we will happily change it for you within the 60 days. For contact lens prescription or brand changes we will exchange out unopened/unmarked boxes purchased from Vision Plus for your new one, even at your next yearly exam. We dispense trial contacts to make sure you are happy with the prescription and fit. Do not open your supply unless you are completely happy with the trials given to you. Please note that any box with a UPC or a box end removed for rebates cannot be returned for credit or exchanges.

All eyewear and glasses lenses have a **1 year warranty** that covers a one-time replacement from the date of purchase. This warranty includes breakage under normal wearing conditions as well as factory defects. This does not include loss or theft. You must be able to bring the whole product in to us at time of replacement.

Thank you for your business and please reach out to us if you have any questions!

By signing below I agree that I have read and understand Vision Plus's return policy and warranty.

________________________________ ________________________________

Patient's Name Printed Date

____

Patient (18+) or Guardian's Signature