

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 _____
 Last 4 SSN _____
 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 _____
 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?

- | | |
|--|--|
| <input type="checkbox"/> Eye Allergies | <input type="checkbox"/> Eye Dryness |
| <input type="checkbox"/> Blurry Vision | <input type="checkbox"/> Burning |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Corneal Abrasions |
| <input type="checkbox"/> Crossed eye/Eye turn | <input type="checkbox"/> Double Vision |
| <input type="checkbox"/> Eye Infections | <input type="checkbox"/> Eye Injury |
| <input type="checkbox"/> Flash of light | <input type="checkbox"/> Floaters/Spots |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Grittiness |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Iritis/Uveitis |
| <input type="checkbox"/> Itchiness | <input type="checkbox"/> Lazy Eye |
| <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Occasional dryness |
| <input type="checkbox"/> Retinal Detachment | <input type="checkbox"/> Sunlight Sensitivity |
| <input type="checkbox"/> Tearing | <input type="checkbox"/> Trouble seeing at night |
| <input type="checkbox"/> Uncomfortable glasses | |
| <input type="checkbox"/> Other eye disorders _____ | |

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? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If so, what medications? _____			
Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Do you use other substances? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Have you ever been diagnosed or treated for the following health problems?			
	<table border="0"> <tr> <td>Yes</td> <td>No</td> </tr> </table>	Yes	No
Yes	No		
Allergies	<input type="checkbox"/> <input type="checkbox"/>		
Rheumatoid Arthritis	<input type="checkbox"/> <input type="checkbox"/>		
Blurred Vision	<input type="checkbox"/> <input type="checkbox"/>		
Double Vision	<input type="checkbox"/> <input type="checkbox"/>		
Fibromyalgia	<input type="checkbox"/> <input type="checkbox"/>		
Osteoarthritis	<input type="checkbox"/> <input type="checkbox"/>		
Heart Disease	<input type="checkbox"/> <input type="checkbox"/>		
Hypertension	<input type="checkbox"/> <input type="checkbox"/>		
Stroke	<input type="checkbox"/> <input type="checkbox"/>		
Crohn's Disease	<input type="checkbox"/> <input type="checkbox"/>		
Ulcers	<input type="checkbox"/> <input type="checkbox"/>		
Multiple Sclerosis	<input type="checkbox"/> <input type="checkbox"/>		
Epilepsy	<input type="checkbox"/> <input type="checkbox"/>		
Fatigue	<input type="checkbox"/> <input type="checkbox"/>		
Trauma	<input type="checkbox"/> <input type="checkbox"/>		
STD	<input type="checkbox"/> <input type="checkbox"/>		
Depression	<input type="checkbox"/> <input type="checkbox"/>		
Panic Disorder	<input type="checkbox"/> <input type="checkbox"/>		
Sore Throat	<input type="checkbox"/> <input type="checkbox"/>		
Leukemia	<input type="checkbox"/> <input type="checkbox"/>		
Asthma	<input type="checkbox"/> <input type="checkbox"/>		
Emphysema	<input type="checkbox"/> <input type="checkbox"/>		
Diabetes	<input type="checkbox"/> <input type="checkbox"/>		
Thyroid Dysfunction	<input type="checkbox"/> <input type="checkbox"/>		
Rosacea	<input type="checkbox"/> <input type="checkbox"/>		
Other: _____			
(Women) Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No
What kind? _____
Solutions used _____
Are you satisfied with the vision and comfort of your contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No
Any interest in color or bifocal contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No
If not already wearing, would you like to try contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is there a family medical history of any of the following: (Please check boxes)
(Mother's or Father's side)
Blindness <input type="checkbox"/> _____
Cataracts <input type="checkbox"/> _____
Corneal Problems <input type="checkbox"/> _____
Diabetes <input type="checkbox"/> _____
Glaucoma <input type="checkbox"/> _____
Heart Disease <input type="checkbox"/> _____
Lazy Eye <input type="checkbox"/> _____
Macular Degeneration <input type="checkbox"/> _____
Retinal Problems <input type="checkbox"/> _____
Other: _____

Family Medical/Eye History
Acknowledgment 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: _____

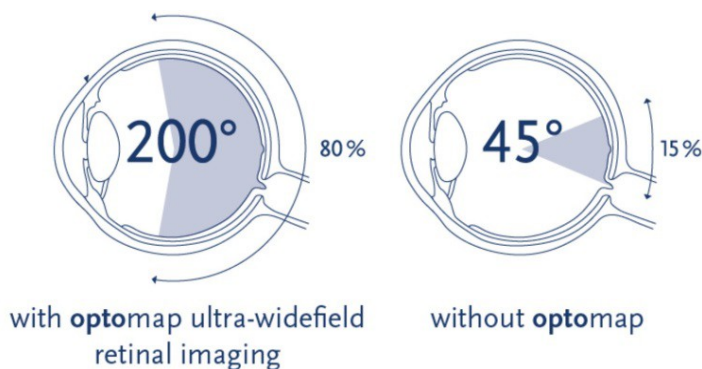
Financial Responsibility
We will be happy to file your medical or vision insurance claims. We will do all we can to help you receive maximum benefits. However, in the event that the plan sponsor determines you are not eligible for coverage at the time of service, or makes a determination that you are 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 \$39.00. 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 / Guardian's Signature