visionplus
for vision. for health. for life.

WELCOME TO OUR OFFICE

Patient Information

Today's Date _______________

Last ___________________________________
First _________________________ MI ______
Birth Date ___________________Age _______
Sex M ___ F___
Street _________________________________
City ________________________ State ______
Zip Code ______________
Cell/Home Phone ___________________
Email __________________________________
Last 4 SSN __________

Work Phone __________________
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
❑ Sign/Building
❑ Google/ 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

****Please Provide Insurance Card***
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/ Social 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 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 family members in need of eyecare?

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

Have you ever experienced or been diagnosed with 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
❑ Eye Dryness
❑ Burning
❑ Corneal Abrasions
❑ Double Vision
❑ Eye Injury
❑ Floaters/Spots
❑ Grittiness
❑ Iritis/Uveitis
❑ Lazy Eye
❑ Occasional dryness
❑ Sunlight Sensitivity
❑ Trouble seeing at night
❑ 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 (List Rx & Over the Counter including eye drops)

____
____
____

Allergies to medications? ❑ Yes ❑ No
If so, what medications? __________________________
____

Have you ever been diagnosed or treated for the following health problems?

	Yes	No
Allergies	❑	❑
Rheumatoid Arthritis	❑	❑
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

Family Medical/Eye History

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: ___________________________________

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.

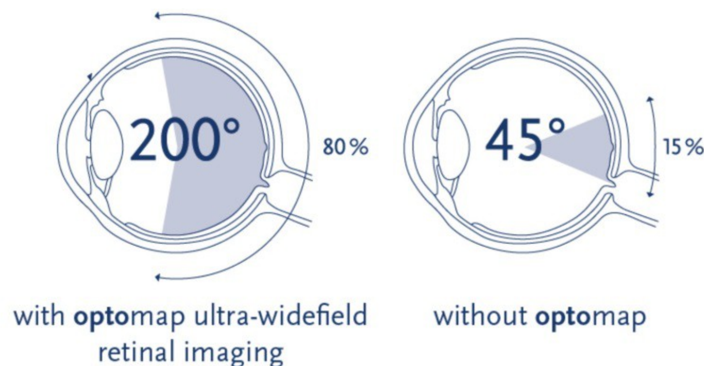
Sign name and date: ____

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 may charge $100.00 or more for similar retinal photos. Dr. Korsgarden has greatly reduced the fee to make it accessible to all of his 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: ___________________

Office Policy and Warranty

Our team is enthusiastic about providing you with great eye care, and finding the right eye wear 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 eye wear 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 were originally seen at our for the current prescription, this office visit is free of charge. If bringing in prescription from another provider, please return with the corrected prescription and we will gladly change it for you within the **60 days**.

Dr. Korsgarden dispenses trial contact lenses at exam to ensure the proper prescription and fit. Specialty and new contact lenses may need to be ordered and may require a follow up visit. Do not open your purchased supply unless you are completely satisfied with the trials given to you. For contact lens prescription or brand changes we will exchange out **unopened, unmarked and unexpired boxes** purchased from Vision Plus for your updated prescription, even at your next yearly exam. **Please note that any box with a UPC or a box end removed for rebates cannot be returned for credit or exchanges.*

All eye glasses (frame and lenses) have a **1 year warranty** for a one-time replacement that covers breakage and scratches from the date of purchase. This warranty includes breakage under normal wearing conditions as well as factory defects. This warranty 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' return policy and warranty.

______________________________ ______________________________

Patient's Name Printed Date

____

Patient / Guardian's Signature