Welcome to ConnectVision Eye Care, P.A.!

Please fill out form as completely as possible and return it to the desk.

Name of Doctor you wish to see ____ Today's Date ____

Patient Name ____ Email Address ____

Address ____ Home Phone ____

Apt # ____ ☐ Male ☐ Female Cell Phone ____

City ____ State ____ Zip Code ____ Work Phone ____

Date of Birth ____ SSN ____ Fax ____

Primary Care Physician ____ Phone ____

Previous Eye Doctor ____ Phone ____

Last Eye Exam ____ Referred By ____

Emergency Contact ____ Phone ____

Vision Insurance Information

Name of Insurance ____ Card Number or I.D. # ____

Insurance Phone # ____ Relationship to Cardholder: ☐ Child ☐ Spouse ☐ Other

Name of Cardholder ____ Group # ____

Cardholder Address ____ Apt # ____

City ____ State ____ Zip ____ Date of Birth ____

Medical Insurance Information

Name of Insurance ____ Card Number or I.D. # ____

Insurance Phone # ____ Relationship to Cardholder: ☐ Child ☐ Spouse ☐ Other

Name of Cardholder ____ Group # ____

Cardholder Address ____ Apt # ____

City ____ State ____ Zip ____ Date of Birth ____

Patient History

Occupation ____ Employer ____

Hobbies / Sports ____

☐ I wear glasses ☐ I wear contact lenses ☐ soft ☐ hard Brand of Contacts ____

Allergies		Ocular History	
Medications		Injuries/Surgeries	

☐ Doesn't Drive ☐ Drives ☐ Doesn't Use Tobacco ☐ Uses Tobacco

Driving Difficulties ______ Type/Amt /How long? ______

☐ Doesn't Drink Alcohol ☐ Drinks Alcohol ☐ Doesn't Use Illegal Drugs ☐ Uses Illegal Drugs

Type/Amt/How Long? ______ Type/Amt/How Long? ______

Have you ever been exposed to or infected with ☐ Gonorrhea ☐ Hepatitis ☐ Syphilis ☐ HIV

☐ Currently Pregnant ☐ Nursing

EYES	☐ Flashes	☐ Weight Loss/Gain	☐ Hormonal Dysfunction	**ALLERGIC/IMMUNE**
☐ Vision Loss	☐ Floating Spots	☐ Fatigue	**RESPIRATORY**	☐ Drug Allergies
☐ Blurry Vision	☐ Tired Eyes	☐ Trauma	☐ Asthma	☐ Seasonal Allergies
☐ Distorted Vision	☐ Cataracts	**INTEGUMENTARY (SKIN)**	☐ Bronchitis	☐ Lupus
☐ Double Vision	☐ Diabetic Retinopathy	☐ Eczema	☐ Emphysema	☐ Arthritis
☐ Dryness	☐ Glaucoma	☐ Rosacea	**CARDIOVASCULAR**	**LYMPH/HEMATOLOGIC**
☐ Redness	☐ Macular Degen.	☐ Psoriasis	☐ Heart Disease	☐ Anemia
☐ Mucous Discharge	☐ Retinal Detachment	**NEUROLOGIC**	☐ Hypertension	☐ Bleeding Problems
☐ Gritty Feeling	**GASTROINTESTINAL**	☐ Headaches	☐ Hypercholesterolemia	☐ Leukemia
☐ Itching	☐ Colitis	☐ Migraines	**EARS/NOSE/THROAT**	**MUSCULOSKELETAL**
☐ Burning	☐ Crohn's Disease	☐ Seizures	☐ Allergies	☐ Fibromyalgia
☐ Excess Watering	☐ Ulcers	☐ Mult. Sclerosis	☐ Sinus Congestion	☐ Muscular Distrophy
☐ Light Sensitivity	☐ Constipation	**ENDOCHRINE**	☐ Runny Nose	☐ Osteoarthritis
☐ Eye Pain/Soreness	☐ Diarrhea	☐ Non Insulin Diabetes	☐ Post Nasal Drip	☐ Ankylosing Spond.
☐ Chronic Infection	**CONSTITUTIONAL**	☐ Insulin Diabetes	☐ Chronic Cough	**GENITOURINARY**
☐ Sties	☐ Fever	☐ Thryoid Dysfunction	☐ Dry Throat/Mouth	☐ STD's
Please list any other symptoms you may be experiencing:				☐ Kidney Problems
				☐ Bladder Problems

Family Medical History: Note relation to yourself in the box (example: “Mother”, “Paternal Grandfather” etc.)

Review of Systems. Please check all that apply to you:

☐ Blindness		☐ Cancer	
☐ Cataract		☐ Diabetes	
☐ Macular Degeneration		☐ Heart Disease	
☐ Glaucoma		☐ High Blood Pressure	
☐ Retinal Detachment		☐ Kidney Disease	
☐ Crossed Eyes		☐ Arthritis	
☐ Lupus		☐ Thyroid Disease	
☐ Other			

Appointment Sign-In

As part of the complete care for your eyes, our doctors will check to make sure your eyes are healthy. With dilation or the images from the Optomap(Retinal imaging), the optometrist will be able to check for signs of glaucoma, diabetic changes, and macular degeneration and holes. For these reasons, our doctors want every patient to either have their eyes dilated or do the Optomap. When you choose the Optomap (Retinal imaging), we take images, which are stored digitally and are easily reviewed from year to year. There are no side-effects and it only takes a couple of minutes.

When you choose dilation instead of Optomap, dilating eye drops will be used to expand your pupils. The dilating drops will make your vision blurry up close for 3-6 hours.

Please let us know, in which way, you would like to have the overall health of your eyes examined:

_________Dilation

_________Optomap Retinal Image ($39 additional charge)

Financial Responsibility

To our patient with Medical and /or Vision benefits: We will be happy to file your insurance claim forms or take assignment of your medical/vision benefits as designated by the Plan(s) of which you state you are a member. We will do all we can to help you receive the maximum benefits. However, in the event that the plan sponsor determines you are not eligible for the date 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 sponsor.

Print Patient Name: ____ Age:__________

Patient Signature (if over age 18): ____________________________________ Date:__________

If the patient is under 18 year of age, please complete the box below, then, sign and date:

Parent/Guardian Name		Relationship to patient: ☐ Parent ☐ Legal Guardian ☐ Other			
Address				Apt #	
City		State		Zip Code	
Cell Phone					
Date of Birth		SSN		Home Phone	
Email Address					

Parent/Guardian Signature: ____________________________________ Date: __________

Acknowledgement of Receipt of Notice of Privacy Practices

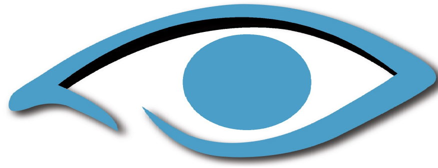
I, the Patient/Parent or Legal Guardian, have received a copy of this office's Notice of Privacy Practices.

____

Printed name of Patient/Parent or Legal Guardian Date

____

Signature of Patient/Parent or Legal Guardian Date



Contact Lens Fitting Agreement

We want you to fully understand our contact lens policy and the services included in our contact lens fees. Fitting contacts is an individualized and personal procedure. Contact lenses are not the answer to every patient's visual needs, and there is no guarantee that every patient will be a successful contact lens wearer.

Trial contact lenses are dispensed for the evaluation purposes only. You must return per the doctor's instructions for your prescription contact lenses. It is your responsibility to strictly adhere to the recommended wearing schedule, lens care procedures, and follow-up appointments. Report any unusual problems including blurred vision, redness, watering of the eye, sensitivity to light, eye discomfort or pain to this office immediately and promptly remove your lenses. We cannot be responsible for unsuccessful wear due to patient non-compliance in following recommended routine. If you have any questions at this time, please ask.

Once payment is received, you are entitled to the following services:

1. Professional fees are not refundable.
2. Dispensing of contacts, care kit, instructional material, and a special training class in the handling care and maintenance of your contacts.
3. Progress evaluation and follow-up care for a period of 60 days without charge.
4. A current prescription for eye glasses and contact lenses.
5. Once the contact lenses/supply have been order or dispensed, it can NOT be returned or canceled.

Texas State law states contact lens prescription expires one year from the following date:_________.
A valid prescription is necessary to obtain replacement lenses.

I have read the contact lens fitting agreement, all my questions have been answered, and I understand and accept the policies for contact lens patients.

____

Patient's Signature and date

____

Dispensers signature and date

____

Parent/Guardian signature if patient is a minor