James F. Anderson, O.D

Visual/Medical History Form

***** If using insurance, be sure to let staff know for proper authorization*****

How did you hear of us? (Check one)

☐ **Friend/Relative** ☐ **Yellow Pages (big/small book)** ☐ **Internet**
☐ **Strip Center/Live in the area** ☐ **Insurance provider** ☐ **Other Advertisement**

Whom may we thank for referring you to us?_____
(Please Give I.D. and Insurance Card to Staff available)

Patient Name: _____ **Date:** _____ **Age:** _____ **Gender: M**☐ **F**☐

Birth date: _____ **Patient Social Security#:** _____

Parents name: _____ **School:** _____
(If Patient is a child)

Social Security # of insured: _____ **Birth date of insured:** _____

Mailing Address:_____ **Home #:** _____
Cell #: _____
_____ **Work #:**_____ **ext:** _____
(City) *(State)* *(Zip)* **E-mail:** _____

Ethnicity: ☐**Hispanic** ☐**Latino** ☐**Non-Hispanic**
Race: ☐**Native American** ☐**Asian** ☐**Pacific Islander** ☐**White** ☐**Black**
Preferred Language: _____
****Primary Vision Care Plan name:** _____ **Occupation:** _____
****Medical Insurance Plan Name:** _____ **Employer:** _____

Driver's License #: _____ **State:** _____

PLEASE CHECK WHAT APPLIES AS TO YOUR REASON FOR SEEKING VISION CARE AT THIS TIME:

- ☐ **General eye exam (Glasses only)**
- ☐ **Contact lenses & general exam (additional fees apply to fit contacts per agreement)**
- ☐ **Red eye, allergy, infection, injury needing care (therapeutic exam)**
- ☐ **Interested in Laser Vision Correction, Corneal Refractive Surgery (i.e. LASIK Surgery)**
- ☐ **Other reason...Explain briefly:** _____

Patient Medical History

- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemic
- ☐ Sickle Cell
- ☐ Fe Deficiency
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Cancer, _____
- ☐ Cholesterol (elevated)
- ☐ Diabetes
- ☐ Drug Sensitivity
- ☐ Heart Condition
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Infectious Disease
- ☐ Multiple Sclerosis
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Respiratory Disease
- ☐ Seizures
- ☐ Sinus problems
- ☐ Skin Condition
- ☐ Stroke
- ☐ Thyroid (Under/Overactive)
- ☐ Tuberculosis
- ☐ Venereal Disease

General Health (Circle One)
Good Fair Poor

Chief Complaint

- ☐ No Visual Complaints
- ☐ Distance blur
  If so, worse at night?_____
- ☐ Near blur
- ☐ Eyestrain, reading
- ☐ Eyestrain, driving
- ☐ Double Vision
- ☐ Flashing lights
- ☐ Floaters/ Spots
- ☐ Headache
  If so, location?_____
- ☐ Light sensitive
- ☐ Temporary vision loss
- ☐ Shifting vision
- ☐ Twitching Lids
- ☐ Red eyes
- ☐ Watery eyes
- ☐ Burning eyes
- ☐ Itchy eyes

Patient Ocular History

- ☐ Allergies
- ☐ Blackouts
- ☐ Cataracts
- ☐ Color deficiency
  If so, color: _____
- ☐ Dry eyes
- ☐ Eye infections
- ☐ Eyelid problems
- ☐ Eye injuries (recent)
- ☐ Glaucoma
- ☐ Lazy eye
  If so, how long: _____

Patient Social History

- ☐ Tobacco.
- ☐ Habitual drinker: _____
- ☐ Alcohol
- ☐ Caffeine

Patient Physical

Height: ___' ___"

Weight: _____lbs.

Body Mass Index: ____

Family Health History

(Immediate Family only)

- ☐ Allergies
- ☐ Asthma
- ☐ Arthritis
- ☐ Bleeding Disorders
- ☐ Blindness
- ☐ Cancer, _____
- ☐ Cataracts
- ☐ Cholesterol (Elevated)
- ☐ Color deficiency
  If so color: _____
- ☐ Diabetes
- ☐ Dry eyes
- ☐ Glaucoma
- ☐ Headache
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Lazy eye
- ☐ Macular Degeneration,
  Age related: _____
- ☐ Migraine
- ☐ Retinal Detachment
- ☐ Skin Condition
- ☐ Thyroid (Under/Overactive)
- ☐ Tuberculosis
- ☐ Turned eye

****COMPLETE BACK****

Are you presently taking medication? ☐ **Yes** ☐ **No**
If yes, which? _____

(If you have a long list, we will copy it for you)

Are you allergic to any medication? ☐ **Yes** ☐ **No**
If yes, which? _____
Other allergies? (i.e. food, dust, pollen, etc...) ☐ **Yes** ☐ **No If yes, what?** _____
Have you ever had any serious eye disease, eye injury, or eye surgery? ☐ **Yes** ☐ **No**
If yes, what and when? _____
Primary, M. D. _____ **Phone #** _____ **Last Visit?** _____
When was your last eye examination? _____ **Who was your previous eye doctor?** _____
Any history of corneal infection/ulcer? _____ **When?** _____ **Which eye?** _____
Do you wear contact lenses? ☐ **Yes** ☐ **No**
If so, which type? Hard ☐ **Soft** ☐ **-Disposable** ☐ **Monthly** ☐ **Yearly** ☐ **Brand:** _____
How many hours do you read close up? _____ **How many hours do you drive?** _____

☐ **Sports & Outdoors** ☐ **Fine Arts** ☐ **Arts & Crafts** ☐ **Other**

Please List Hobbies: _____

PATIENT FINANCIAL RESPONSIBILITY

*** * * Professional service fees are NON-refundable * * ***

***PLEASE READ* I authorize Anderson Vision Center to apply for benefits on my behalf for covered services rendered by them, and assign payments made directly to Anderson Vision Center. I agree to assume responsibility of full payment pending any remaining balance that is not covered by my insurance. I hereby authorize the vision care provider to pay Anderson Vision Center, J. F. Anderson O. D. for products and service rendered if the insurance company/Vision plan denies or underpays any claims, I agree to assume reasonability of full payment.**

I certify that the information I have reported with regard to my coverage is correct. I further authorize this vision care provider to release to my insurance and its agents any information related to this or any related claim. However we can only do so if notified prior to your scheduled appointment. After your exam is completed and the materials are purchased, we are unable to file.

**** If we are not providers for your insurance, we will help you complete your insurance form ****

Dilation Release Form

Our office offers dilation for everyone as part of our routine eye exam.

I have been informed that my pupils will bedilated in order to have a complete eye examination. I understand that for a period of 4—12 hours following dilation my eyes will sensitive to sunlight, unable to focus on close objects, and may have to restrict major activities such as driving a vehicle, operating machinery or any other activity where visual discretion is necessary.

I hereby release James F Anderson O. D., his employees and office staff from responsibility relating to dilation of my pupils on this date which might result in injury to myself or any other person or persons.

I want to be dilated today Yes_____No_____

If not, why_____

ACKNOWLEDGEMENT OF RECEIPTS

*** * *Under Health insurance portability and accessibility Act (HIPAA), I acknowledge that I have received a copy of notice of privacy practices (NPP) from Dr. James F. Anderson, O. D.* * ***

I authorize the release of certain medical or other information necessary, to process an insurance/vision claim and/or to make a referral to another doctor on my behalf, if needed.

I authorize the release of medical records or materials, to family members and/or friends. If preferred to *only* give information to certain individuals be list below, if not leave blank.

_____

_____

(Listed individuals must have a form of ID)

List Individuals Here

I have read and acknowledged all information on this form.

Sign Here

_____ _____

Patient Signature ***or*** **Legal guardian, *if under 18*** **Date**