VISION SPECIALISTS
Of Council Bluffs

Last Name: _____ First Name: _____Middle Initial: _____

Street Address: _____ Apt#: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Gender: _____ Race: _____ Ethnicity: _____

Pediatrician/Family Physician: _____

Who can we thank for referring you to our office? _____

Parent/Guarantor Information

Last Name: _____ First Name: _____Middle Initial: _____

Street Address: _____ Apt#: _____

City: _____ State: _____ Zip Code: _____

Relationship: _____ Home Phone: _____ Cell Phone:_____

☐YES, please send appointment reminders via text message.

Email Address: _____

Additional Parent/Guarantor Information

Name: _____ Relationship: _____Phone Number: _____

Name: _____ Relationship: _____Phone Number: _____

Insurance Information

Primary Card Holder's Name: _____ Relationship: _____

Address: _____ Date of Birth: _____

Social Security # (last 4 digits): _____Contact Phone #: _____ Employer: _____

Notice of Privacy Practices, Authorization to Release Information to Insurance Company, & Acknowledgement of Responsibility for Payment

I acknowledge I have been offered or received a copy of this practice's NOTICE OF PRIVACY PRACTICES. I understand that Vision Specialists of Council Bluffs (VSCB) is a healthcare provider and may share the patient's health information for treatment, payment, and healthcare operations.

I hereby assign all medical benefits (to which the patient is entitled) to the doctor caring for this patient. VSCB will file insurance coverage for patient if provided with a copy of current insurance card. This includes any health plans in which patient is enrolled. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not they are paid by patient's insurance. I hereby authorize the holder of the patient's medical and patient registration records to release any information needed to process the insurance claims. I understand that I am the guarantor of this account. A copy of the patient's medical records can be requested in writing and will be provided to me or whomever I designate for $15.00. I do acknowledge that there is a $25.00 fee for returned checks. I am aware that if the patient does not have insurance coverage, I will be responsible for payment. Payment is due at the time of service.

Parent/Guarantor Signature: _____ Date: _____

Patient History

Reason for today's visit?

_____

_____

Date of last eye exam? _____

Who performed last exam? _____

Currently wear glasses? ☐ Yes ☐ No

Currently wear contacts? ☐ Yes ☐ No

Have you or a family member (list relationship) experienced or been treated for any of the following?

Cataracts ☐ me ☐ family _____

Crossed Eye ☐ me ☐ family_____

Lazy Eye ☐ me ☐ family _____

Glaucoma ☐ me ☐ family _____

LASIK or RK ☐ me ☐ family _____

Macular Degeneration ☐ me ☐ family _____

Retinal Detachment ☐ me ☐ family _____

Other Eye Surgery_____

Eye Injuries _____

Are you currently experiencing, or have recently experienced, any of the following?

☐ Blurry Vision (near or distance)

☐ Loss of Vision

☐ Loss of Side Vision

☐ Double Vision

☐ Glare / Halos / Light Sensitivity (day or night)

☐ Flashes / Floaters in Vision

☐ Tired Eyes

☐ Excess Tearing / Watering

☐ Itching

☐ Redness

☐ Dryness

☐ Headaches

Do you plan on getting glasses today? ☐Yes ☐ No

Do you plan on getting contacts today? ☐Yes ☐ No

Hobbies: _____

_____

Have you or a family member (list relationship) experienced or been treated for any of the following?

AIDS/HIV ☐ me ☐ family _____

Allergies ☐ me ☐ family _____

Arthritis ☐ me ☐ family _____

Asthma ☐ me ☐ family _____

Blood/Lymph Disorder ☐ me ☐ family _____

Cancer (Type) ☐ me ☐ family _____

Diabetes ☐ me ☐ family _____

Ears, Nose, Throat Conditions ☐ me ☐ family _____

Gastrointestinal Conditions ☐ me ☐ family _____

Heart Disease ☐ me ☐ family _____

High Blood Pressure ☐ me ☐ family _____

High Cholesterol ☐ me ☐ family _____

Kidney Disease ☐ me ☐ family _____

Lupus ☐ me ☐ family _____

Neurological Conditions ☐ me ☐ family _____

Psychiatric Disorder ☐ me ☐ family _____

Seizures ☐ me ☐ family _____

Skin Conditions ☐ me ☐ family _____

Stroke ☐ me ☐ family _____

Thyroid Dysfunction ☐ me ☐ family _____

Do you have any known allergies to medications?

☐Yes ☐ No If yes, please explain:

_____

_____

Current Medications (prescription and over-the-counter)

_____

_____

_____

_____

_____

Height: _____ **Weight:** _____