Welcome Sheet

Personal Information

Last Name _____ Today's Date _____

First Name _____ Initial____ Date of Birth _____ Age____

Name you prefered to be called_____ Social Security_____

Title: ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. ❑ None Suffix___ Gender: ❑ Male ❑ Female

Is Patient a child under the age of 18? ❑ No ❑ Yes Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Address #1_____ Name of Spouse (If applicable)_____

Address #2_____ Name of Children (If applicable) _____

City _____ Medical Insurance _____

State _____ Zip_____ Employment Status _____

Home Phone _____ Employer _____

Daytime Phone _____ Occupation _____

Cell Phone _____ How did you hear about our office? _____

Fax Number_____

E-Mail _____

Insurance Information

Name of insurance company for vision care _____

Policyholder Name _____ Policyholder's Date of Birth_____

Member ID # _____ Name of Employer_____

Work Phone _____ Employer Address_____

City _____ State_____ Zip_____

AUTHORIZATION AND ASSIGNMENT OF BENEFITS: By signing this form below, I authorize the release of any medical information necessary to process this claim and request payment of medical benefits to be made directly to Corgan Vision Clinic unless payment is made in full at the time of service. I also understand that it may be necessary for me to bill my own insurance company directly for any secondary coverage.

Financial Responsibility

Your signature on this form acknowledges that you, the patient, agree to bear full responsibility for all services provided if:

1. It is determined that you are not eligible for insurance coverage.
2. The services are not covered under your benefit plan or we were not made aware of your coverage at the time of services. (Some non-contracted insurance companies have disclaimers starting that they will not guarantee coverage as quoted over the phone at the time of our coverage inquiry.)
3. The services have not been referred and/or authorized as required by your health plan.
4. You are seeking services "out of network" with a non-contracted provider.
5. 50% down is required upon ordering of any materials.

We reserve the right to charge a $25.00 fee for all missed appointments that have not been cancelled 24 hours prior to the scheduled appointment time. This is because a block of time in the doctors schedule has been allotted to you and may remain unusable by another patient.

All charges are due and payable at the time of service unless otherwise specified by an insurance company contracted with us.

I have read and understand the above stated office policies. By signing this form, I agree to comply with these policies:

Signature _____ Date _____

Acknowledgement of Receipt of Notice of Privacy Practices:

My signature below verifies that I have received a copy of the Corgan Vision Clinic Notice of Privacy Practices.

Name of Patient (print) _____ Signature of Patient _____ Date_____

Signature of Patient Representative (if patient is a minor or an adult unable to sign this form) _____

Relationship of Patient Representative to Patient _____

Name of Party Allowed to receive any information on your behalf _____

Patient Name _____ Chart # _____

Name and Location of Primary Care Medical Doctor: _____

Drug Allergies: ❑ None ❑ Yes (if yes, please list) _____

Environmental Allergies: ❑ None ❑ Yes (if yes, please list) _____

Are you experiencing any of the visual problems while wearing your glasses or contact lenses:

Difficult reading small print?	❑ Yes	❑ No	Bothered by glare/halos?	❑ Yes	❑ No
Difficulty Driving?	❑ Yes	❑ No	Eyestrain with computer work?	❑ Yes	❑ No

Have you ever been diagnosed with, or treated for any of the following:

Allergic/Immunologic
- ❑ drug allergy
- ❑ environmental allergy
- ❑ rheumatoid arthritis
- ❑ lupus
- ❑ other
- ❑ meds

Cardiovascular
- ❑ heart disease
- ❑ hypertension
- ❑ stroke
- ❑ vascular disease
- ❑ other
- ❑ meds

Constitutional
- ❑ developmental disability
- ❑ weight loss
- ❑ fever
- ❑ fatigue
- ❑ trauma
- ❑ other
- ❑ meds

Ears, Nose, Mouth & Throat
- ❑ Upper Resp. Tract Infect
- ❑ other
- ❑ meds

Endocrine
- ❑ non-insulin dependent diabetes
- ❑ insulin-dependent diabetes
- ❑ thyroid dysfunction
- ❑ hormonal dysfunction
- ❑ other
- ❑ meds

Eyes
- ❑ GLC
- ❑ CAT
- ❑ AMD
- ❑ Surgery
- ❑ Inflammatory disorders
- ❑ other
- ❑ meds

Gastrointestinal
- ❑ Crohn's
- ❑ colitis
- ❑ ulcer
- ❑ digestive
- ❑ other
- ❑ meds

Genitourinary
- ❑ STD - viral herpetic, chlamydia
- ❑ other
- ❑ meds

Hematologic/Lymphatic
- ❑ anemia
- ❑ large volume blood loss
- ❑ leukemia
- ❑ other
- ❑ meds

Integumentary
- ❑ eczema
- ❑ rosacea
- ❑ psoriasis
- ❑ other
- ❑ meds

Musculoskeletal
- ❑ fibromyalgia
- ❑ muscular dystrophy
- ❑ osteoarthritis
- ❑ ankylosing spondylitis
- ❑ other
- ❑ meds

Neurological
- ❑ multiple sclerosis
- ❑ epilepsy
- ❑ other
- ❑ meds

Psychiatric
- ❑ depression
- ❑ panic disorder
- ❑ schizophrenia
- ❑ other
- ❑ meds

Respiratory
- ❑ cigarette smoker
- ❑ asthma
- ❑ bronchitis
- ❑ emphysema
- ❑ other
- ❑ meds

Please list all prescribed and over the counter medications you are currently taking:

Name of Medication	For what condition/Dosage	Name of Medication	For what condition/Dosage

Do you use eye drops? ❑ Yes ❑ No

Patient Eye History: Do you have or have you ever had any of the following? (Please check if answer is Yes)

❑ Cataracts ❑ Glaucoma ❑ Macular Degeneration ❑ Retinal Problems ❑ Diabetic Retinopathy ❑ Eye Muscle Problems

❑ Optic Nerve Problems ❑ Other _____

Family Eye/Health History? Does anyone in your **immediate** family (blood relatives) have any of the following? List relationship if Yes.

❑ Cataracts _____ ❑ Glaucoma _____ ❑ Macular Degeneration _____ ❑ Diabetic Retinopathy _____

❑ Eye Muscle Problem _____ ❑ Retinal Detachment _____ ❑ Blindness _____ ❑ Other Ocular Problems _____

❑ Diabetes _____ ❑ High Blood Pressure _____ ❑ Heart Disease _____ ❑ Stroke _____ ❑ Cancer _____

Contact Lenses:

Have you ever worn contact lenses? ❑ Yes ❑ No If yes, last Doctor's office that provided the prescription _____

Are you interested in contact lenses today? ❑ Yes ❑ No

Which pharmacy do you use for your prescriptions? Name _____ Location _____

I have answered the above questions to the best of my knowledge.

Patient or Guardian Signature _____ Date _____

FOR OFFICE USE ONLY: (please date and initial) Reviewed/Amended on _____ by _____