



TOTAL VISION CENTERS



PATIENT INFO

Date _____ New Patient Previous Patient

Name _____

Address _____

Telephone (H) _____ (W) _____

Cell Phone _____

Best time and place to reach you _____

Social Security # _____

Sex M F Age _____ Birthdate _____

Single Married Widowed Separated Divorced

Student? Y N Grade/School _____

Patient's Occupation _____

Employer _____

Parent or Spouse's Name _____

Parent or Spouse's Employer _____

Parent or Spouse's Work Phone _____

Emergency Contact _____ Relationship _____

Telephone (H) _____ (W) _____

VISION INFO

Date of last eye exam _____ Doctor _____

Do you wear glasses? Y N

Do you wear contacts? Y N

If no, are you interested in contacts? Y N

Brand/Type _____ Hours/Days _____

Describe any problems with your contacts _____

Reason for today's visit _____

RESPONSIBLE PARTY/INSURANCE INFO

Person responsible for this account _____

Relationship to patient _____

Insurance Co. _____

Subscriber Name _____

Subscriber ID# _____ Group# _____

INSURANCE ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to either Dr. DuBro/Kuhn all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature _____

Relationship _____ Date _____

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare Benefits be made either to me or on my behalf to Dr. DuBro/Kuhn for any services furnished me by that doctor. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agent any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Signature of Beneficiary _____

Date _____

MEDICAL INFORMATION

Do you or any relatives have problems with any of these systems? (please circle all that apply)

| System | Yourself | Relative (parent/child/sibling) | Do you have diabetes? | Y / N |
|----------------------|----------|---------------------------------|------------------------------------|-------|
| Gastrointestinal | Y / N | Y / N | Type _____ Date of diagnosis _____ | |
| Ear/Nose/Throat | Y / N | Y / N | High blood pressure? | Y / N |
| Cardiovascular | Y / N | Y / N | Have you had any operations? | Y / N |
| Respiratory | Y / N | Y / N | Other health problems _____ | |
| Genitourinary | Y / N | Y / N | _____ | |
| Musculoskeletal | Y / N | Y / N | Are you pregnant or nursing? | Y / N |
| Nervous | Y / N | Y / N | Do you consume alcohol? | Y / N |
| Skin | Y / N | Y / N | Do you use cigarettes or tobacco | |
| Endocrine | Y / N | Y / N | products? Y / N Kind _____ | |
| Mental | Y / N | Y / N | # of packs per day _____ | |
| Blood/Lymph | Y / N | Y / N | Other substances? | Y / N |
| Allergic/Immunologic | Y / N | Y / N | | |

Please explain _____

Name of family physician _____ Date of last visit _____

PERSONAL EYE INFORMATION

| | | | | | |
|-------------------------------------|-------|-----------------------|-------|---------------------|-------|
| Do you have Glaucoma? | Y / N | Cataracts? | Y / N | Blurred vision? | Y / N |
| Dry eyes? | Y / N | Macular degeneration? | Y / N | Retinal detachment? | Y / N |
| Have you ever had an eye operation? | Y / N | Type _____ | | Date _____ | |
| Have you ever had an eye injury? | Y / N | Kind _____ | | Date _____ | |
| Other eye problems? | Y / N | What kind? _____ | | | |

FAMILY HISTORY

| | | | | | |
|------------------------|-------|------------------|----------------------|-------|----------------|
| Diabetes | Y / N | Relation _____ | Macular degeneration | Y / N | Relation _____ |
| High blood pressure | Y / N | Relation _____ | Retinal detachment | Y / N | Relation _____ |
| Glaucoma | Y / N | Relation _____ | Cataracts | Y / N | Relation _____ |
| Other eye condition(s) | Y / N | What kind? _____ | | | |

MEDICATIONS

List any medications you are currently taking, including over-the-counter medications, herbal remedies and vitamins. None

| Name of Medication | Dosage |
|--------------------|--------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

ALLERGIES

List any allergies to medications or other substances, such as sulfa. None

| |
|-------|
| _____ |
| _____ |
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| _____ |
| _____ |
| _____ |

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