Dyer Vision Center Patient Information Form

Welcome to Dyer Vision Center. We appreciate you trusting us for your eye care. In order for us to be compliant with government mandated electronic medical record keeping, please fill out this form in its entirety.

Last Name: ____________________ First Name: __________________ MI____ Preferred Name: __________________

Address: _____________________________City: ____________________ State: ________ Zip Code: _____________

SSN: ________-_______-_________ Sex: ☐ M ☐ F Date of Birth: _______/_______/_______

Occupation____ Employer_____________________________________

Methods of Communication: ***(Please number the top three methods in the order of your preference 1-3).***

___Home Phone: ____________________________ ___Work Phone: ____________________________

___Cell Phone: _____________________________ ___Other Phone: ____________________________

Do you accept text messages? ☐ yes ☐ no ___Email: _________________________________

(confidential: for medical practice use only)

How did you hear about our office? ☐ Friend/family ☐ Location ☐ Yellow Pages ☐ Lions Club ☐ Facebook ☐ Other: _____________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other

To help us associate families, please list these family members below:

Spouse: ________________________________DOB:___/___/____Guardian/Guarantor: __________________________

Father: ____ Mother: ____

Preferred language: ____________________________ (spoken) ___________________________________ (written)

Ethnicity: ☐ Of Hispanic or Latino origin ☐ NOT of Hispanic or Latino origin

Race: ☐ African American ☐ Caucasian ☐ Alaskan Native ☐ American Indian ☐ Asian ☐ Pacific Islander ☐ Other

Insurance Information:

Primary (*MEDICAL*) Plan Name: ______________________________ Policy/Member #:________________________

Claims Mailing Address: ____ Group #: _________________________

Insured Individual (If other than patient):__________________________ DOB: ____/___/_____ SS#: _____-____-_____

Secondary (*VISION*) Plan Name: ____

Insured Individual (If other than patient):________________________ DOB: _____/___/_____ SS#: ______-____-_____

Other Insurance Plan Name: ____

Insured Individual (If other than patient):________________________ DOB: _____/___/_____ SS#: ______-____-_____

Consent for Treatment:

I consent to an eye exam at Dyer Vision Center for myself or my dependent, including any procedures legally defined as the Practice of Optometry in Missouri. I understand and agree that I am financially responsible for my account if rejected by my insurer. I hereby authorize release of any information necessary to file an insurance claim. I also authorize the release of information to another doctor or other qualified person if necessary for my care.

Signature: ____ Date: __________________________________

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Last Name: ____________________ First Name: _____________________ DOB: ____/____/____ SS#:____-____-____

Date of last eye exam: _____/_____/_____Previous Optometrist: ___________________Location: __________________

Date of last physical exam: ____/_____/____Physician:__________________________ Location: __________________

Have you had surgery within the past 12 months? ☐ Y ☐ N If yes, please describe:

____

Height: _________________________ Weight: _________________________ Are you pregnant? ☐ Y ☐ N

Do you have/wear?	Y	N	?	**Diagnosed with?**	Y	N	?	**Do You?**	Y	N	?
Eye glasses	☐	☐	☐	Glaucoma	☐	☐	☐	Use tobacco	☐	☐	☐
Reading glasses	☐	☐	☐	Dry eyes	☐	☐	☐	Drink alcohol	☐	☐	☐
Contact lenses	☐	☐	☐	Retina problems	☐	☐	☐	Work in eye hazard area	☐	☐	☐
If õYesö, are they?				Cataracts	☐	☐	☐	Work around toxic fumes	☐	☐	☐
Hard	☐	☐	☐	Blurred vision	☐	☐	☐	Work around toxic materials	☐	☐	☐
Soft	☐	☐	☐	Amblyopia (lazy eye)	☐	☐	☐	**Have you ever had?**			
Toric (astigmatism)	☐	☐	☐	Macular degeneration	☐	☐	☐	Eye surgery	☐	☐	☐
Spherical	☐	☐	☐	Iritis	☐	☐	☐	Eye injury	☐	☐	☐

Y	N	**Are you being treated for any of these medical conditions? If "Yes", please explain.**
☐	☐	Cardiovascular (Heart, High Blood Pressure)
☐	☐	Respiratory (Asthma, Emphysema)
☐	☐	Gastrointestinal (Stomach, Ulcer)
☐	☐	Muscles, Bones, Joints (Arthritis)
☐	☐	Skin (Acne, Skin Cancer)
☐	☐	Neurological (Multiple Sclerosis, Headaches)
☐	☐	Psychiatric (Anxiety, Depression)
☐	☐	Endocrine (Diabetes, Hypothyroid)
☐	☐	Blood/Lymph (Anemia, HIV)
☐	☐	Allergic/Immunologic (Lupus, Hay Fever)
☐	☐	Genitourinary (Kidney, Bladder, Prostate)
☐	☐	Ear, Nose, Throat
☐	☐	Other Diagnosed Health Issues

List all medications you are currently taking (or if you carry a current list with you, allow us to make a copy):

____

____

Are you allergic to any medications? ☐ Y ☐ N If yes, please list:

____

DIAGNOSTIC INFORMATION

Do you experience?	**Y**	**N**	**Do you have difficulty with?**	**Y**	**N**
Discomfort with eyes			Reading small print such as labels, newspaper		
Sensitivity to light			Driving during day or night (circle which one)		
Mucus or drainage from the eyes			Reading traffic signs, street signs or watching tv		
Headaches (more than 1 per week)			Doing fine handwork like writing checks or sewing		
Floaters or flashes of light			Seeing rings or halos around lights		

FAMILY HISTORY

Has a family member had?	**Y**	**N**	**Relationship:**	**Has a family member had?**	**Y**	**N**	**Relationship:**
High blood pressure				Retinal detachment			
Diabetes				Cataracts			
Glaucoma				Other eye condition			
Macular degeneration							

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Financial & Office Policies

Initial ______ **SELF PAY:** If I do not have proof of insurance coverage at the time services are rendered, I understand that full payment is due at the time of service.

Initial ______ **PAYMENTS:** I will promptly pay all amounts that have been determined my responsibility by my insurance carrier upon receipt of my statement. I understand that my vision and/or health insurance is between my insurance company and myself. Any balance remaining after my health insurance pays, denies or deems non-covered under my plan will be my responsibility. If my insurance company does not pay for services rendered by Dyer Vision Center, Inc. within 45 days, I will be responsible for those charges and will make immediate payment.

Initial ______ **APPOINTMENTS & LATE ARRIVALS:** We require patients to arrive on time for their appointments. When patients arrive late, it is impossible to stay on schedule. If you arrive more than 15 minutes past your scheduled appointment time, you may either be rescheduled so that other patients are not inconvenienced or if you prefer to wait, you may be seen when the day's schedule permits.

Initial ______ **CHECK IN:** Bring your current insurance card(s) with you at each visit. We will ask you to verify insurance and demographic information so that our records remain current. Please come prepared to pay. If you do not have your copay or are not prepared to pay past due balances, your appointment may be rescheduled for a later time when you are able to meet your payment obligation.

Initial ______ **CHECK OUT:** Co-pays, charges for services rendered not covered by your insurance company, and past due amounts are due at the time you check out.

Initial ______ **NO SHOWS:** We expect patients to give us notice (usually 24 hours prior) if they are not going to keep their appointments. When you make a commitment to an appointment, other patients lose the opportunity of scheduling that date or time. Giving us sufficient notice allows us to schedule a patient on our wait list.

Initial ______ **SERVICE FEES:** Your account will be charged $25 for insufficient funds or returned checks. The practice may ask for assistance from an outside collection agency if you fail to pay or make arrangements for payment. If your account is turned over to a collection agency, a non-reversible service fee of $40 will be assessed and you will be dismissed from the practice. We will make every effort to avoid this action.

I have read, understand and agree to the above financial and office policy. I also understand that non-compliance with this policy may result in termination of my care at this practice.

Patient Name: (Please Print) ____ Date: ______________

Patient Signature: ____