Welcome to Wise Vision Care

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions we will be glad to help you.

1 - PATIENT INFORMATION

Date _____

Patient Name _____

Address _____

_____

Phone # (s) _____

Email _____

Sex ❑ M ❑ F Age_____ Birthdate_____

❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed

Patient Soc. Sec.# _____

D.L.# or I.D.# _____

Occupation _____
(or school -if student)

Employer _____

Work Phone # _____

Hobbies / Interests _____

Spouse's/Gaurdian's Name (Circle One)_____

How did you hear about Wise Vision Care?

❑ Phone Book ❑ Television ❑ Newspaper ❑ Magazine

❑ Internet ❑ Sign ❑ Insurance List

❑ Personal Referral (who?)

❑ Other _____

2 - INSURANCE INFORMATION

Name of Account Holder _____

Relationship to Patient _____

❑ Medicaid ❑ Medicare ❑ Tricare Prime

❑ BCBS name of policy _____

❑ Other Plan _____

Group / ID # _____

Additional / Supplemental

Policies _____

Group / ID #_____

Account Holder Soc. Sec. # (If different from ID #)

_____

Account Holder Birthdate _____

I, the undersigned certify that I (or for my dependent) have insurance coverage with the group(s) specified above and assign directly to Drs. Warren and / or Farah Wise 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 Dr. Wise to release all information necessary to secure the payment of benefits. I have been given a copy of the Wise Vision Care Notice of Privacy Practices.

_____

Responsible Party Signature

_____ _____

Relationship Date

3 - EYE HEALTH HISTORY

Date of last eye exam _____

Doctor's name _____

Glasses History: ❑ never worn ❑ for distance (e.g. driving, TV) only

❑ for near (e.g. reading, computer) only ❑ full time wear

How old is your current prescription?_____

Contact Lens History: ❑ never worn ❑ soft disposable

❑ hard / RGP ❑ specialty lens _____

How many years in contact lenses?_____

Do you sleep in your contacts? ❑ never ❑ occasionally ❑ often

What brand(s) / type(s) do you wear (E.G. Airoptix, Acuvue Oasys, etc)?

_____

Do you wear toric contacts for astigmatism? ❑ Yes ❑ No ❑ Not sure

Describe any problems you have had with your contacts:_____

_____

What is your main purpose for today's visit?

❑ exam for glasses prescription ❑ exam for contact lens prescription

❑ exam for laser surgery evaluation ❑ exam for "pink eye" / infection

❑ other reason:_____

_____

Mark on "Yes" or "No" if you currently have any of the following:

bloodshot eyes	❑ yes	❑ no	eye injury	❑ yes	❑ no
blur at distance	❑ yes	❑ no	eye strain	❑ yes	❑ no
blur at near	❑ yes	❑ no	floaters / spots	❑ yes	❑ no
burning eyes	❑ yes	❑ no	glaucoma	❑ yes	❑ no
cataracts	❑ yes	❑ no	headaches	❑ yes	❑ no
dim vision	❑ yes	❑ no	itchy eyes	❑ yes	❑ no
discharge (eyes)	❑ yes	❑ no	light sensitivity	❑ yes	❑ no
dizzy spells	❑ yes	❑ no	seeing flashes	❑ yes	❑ no
dry eyes	❑ yes	❑ no	twitching eyelid	❑ yes	❑ no
eye infection	❑ yes	❑ no	watery eyes	❑ yes	❑ no

- OVER -

4 - HEALTH HISTORY

Primary Doctor's Name(s):_____ Date of last visit? _____

Mark on "Yes" or "No" if you have, or a blood relative has had, any of the following problems:

	Yourself	Family Members
AIDS / HIV	❑ yes ❑ no	❑ yes ❑ no
Arthritis	❑ yes ❑ no	❑ yes ❑ no
Asthma	❑ yes ❑ no	❑ yes ❑ no
Blindness	❑ yes ❑ no	❑ yes ❑ no
Cancer	❑ yes ❑ no	❑ yes ❑ no
Cataracts	❑ yes ❑ no	❑ yes ❑ no
Cholesterol	❑ yes ❑ no	❑ yes ❑ no
Chemical Dependency	❑ yes ❑ no	❑ yes ❑ no
Depression	❑ yes ❑ no	❑ yes ❑ no
Diabetes	❑ yes ❑ no	❑ yes ❑ no
Epilepsy	❑ yes ❑ no	❑ yes ❑ no
Eye Surgery	❑ yes ❑ no	❑ yes ❑ no
Glaucoma	❑ yes ❑ no	❑ yes ❑ no
Hay Fever	❑ yes ❑ no	❑ yes ❑ no
Heart Condition	❑ yes ❑ no	❑ yes ❑ no
Hepatitis (Type ____)	❑ yes ❑ no	❑ yes ❑ no
High Blood Pressure	❑ yes ❑ no	❑ yes ❑ no
Lazy Eye	❑ yes ❑ no	❑ yes ❑ no
Lupus	❑ yes ❑ no	❑ yes ❑ no
Migraine Headaches	❑ yes ❑ no	❑ yes ❑ no
Retinal Disease	❑ yes ❑ no	❑ yes ❑ no
Stroke	❑ yes ❑ no	❑ yes ❑ no
Thyroid Condition	❑ yes ❑ no	❑ yes ❑ no
Tuberculosis	❑ yes ❑ no	❑ yes ❑ no
Turned Eye	❑ yes ❑ no	❑ yes ❑ no
Major Surgery	❑ yes ❑ no	Describe_____
Do you drink alcohol?	❑ yes ❑ no	

Last A1C# _____ Date_____

Are you pregnant? ❑ yes ❑ no Do you smoke? ❑ yes ❑ no

Any health conditions other than those listed above? _____

5 - MEDICATIONS

List all medications you are currently taking, including eye drops. Also, include over-the-counter medications as well as prescription medications:

_____

_____

_____

_____

_____

Pharmacy Name _____

Phone Number _____

6 - ALLERGIES

List all known allergies to medications or other substances:

_____

_____

_____

_____

7 - DILATION ACCEPTANCE / REFUSAL

Dilated fundus examinations involve the use of eyedrops which allow a more thorough evaluation of the internal eye. Refusal of dilated fundus examinations may result in inability to detect potentially sight- or life-threatening diseases. Side-effects of the eyedrops used in this procedure may hamper your ability to focus and cause sensitivity to light for several hours. In some cases, a dilation may be necessary to obtain an accurate glasses prescription.

❑ I wish to be dilated at the comprehensive eye exam (or whenever the doctor deems necessary).

❑ I do not wish to be dilated at any eye exam.

❑ I would like to discuss the procedure with the doctor.

_____ _____

Signature of Patient (or legal guardian) Date

8 - MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made on my behalf to Drs. Warren and/or Farah Wise 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 agents 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 of the 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 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