Ford Vision Clinic Patient Data Sheet

❑ **Please check here if you are a new patient. All blanks on all pages must be filled out.**

❑ **Please check here if you are a returning patient. If any information has changed, please update it below. If nothing has changed, please leave blank. Returning patients must sign the Privacy Policy and fill out both pages.**

Name ____ **Date of Birth** ________________

Address ____

City ________________________________ **State** ______________ **Zip** ________________

Email Address ____

Cell Phone ___________________________ **Home Phone** ____________________________

List the names of people authorized to receive information about patient:

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Preferred Form of Communication (please circle) **Phone** **Text** **Email**

Race: ________________ **Gender:** ________________

How did you hear about us? ____

Employer: _______________________________ **Occupation:** ________________________

Medical Insurance: ______________ **Policy Holder:** ______________ **Policy ID#:** ______________

Vision Insurance: ______________ **Policy Holder:** ______________ **Policy ID#:** ______________

Policy Holder's Date of Birth: ____________ **Policy Holder's Social Security Number:** ______________

Privacy Policy

In order to ensure compliance with Health Care Information Portability and Accessibility Act of 1996 **(HIPAA)**, this practice has established a privacy policy to provide for the security of your medical records. All patient records shall be stored on an encrypted computer system with access restricted to qualified personnel. No patient information shall be shared with another health care provider without the patient's written, signed consent with the exception of a medical emergency where the patient's life may be compromised without said information. No patient information, including but not limited to medical information, demographic information, lifestyle information, and financial information shall be released for the purpose of marketing outside of the practice. Any and all computer terminals containing patient information are secured by password protection with only qualified staff possessing a password to access the computer systems. If you have any questions or concerns about your privacy and your medical records, please do not hesitate to ask the doctor or our staff members.

Patient Signature: ____ **Date:** ______________

Parent/Guardian Signature (if pt is under 18) ______________________________ **Date:** ___________

FORD VISION CLINIC REFRACTION POLICY

A refraction is a test generally used to determine your glasses or contact lens prescription. If you have a medical diagnosis, your visit must be billed to your medical insurance; unfortunately most medical insurances do not cover refractions. We are required by insurance to bill the patient for the service. The fee for this service will be up to $58 pending your coverage.

Please Circle: Agree Disagree

DILATION CONSENT

It is our goal to provide a complete and thorough comprehensive eye examination. To effectively accomplish our goal, we feel it is important to dilate the pupils of your eyes. This will require placing drops in your eyes which will open the pupil and allow a better view of the inside of your eye.As with many medications, there are some side effects of the drops used to dilate the pupil. These include sensitivity to light and blurred vision (in most cases the distance vision will be unaffected). The side effects usually last several hours but rarely last as long as 24 hours.While we believe dilation is an important part of the eye examination process, we understand that some patients may wish to omit this procedure. There is no additional fee for this service.

Please Circle: Agree Disagree

RETINAL SCREENING IMAGE

Screening is part of a wellness program to check for diseases that may otherwise go undetected. Your insurance recommends that you have this done for a baseline and then yearly to compare and track for eye disease. Our doctors will go over the results of the test and show these images to you in the exam room. **The charge for this test is $39.00 and is not covered by insurance.**

Please Circle: Agree Disagree

FORD VISION CLINIC INSURANCE POLICY

As a courtesy to our patients we will file insurance claims for all insurance plans in which we participate in. We are happy to file for you as long as you provide us with complete information prior to being seen by the doctor. Any charges not covered by your insurance are due at time of service unless other arrangements have been made ahead of time. You are responsible for any copayments and deductible amounts or any non-covered services on the day services are rendered. There are two types of insurance that cover eye care, vision insurance and medical insurance. Vision Insurance covers your annual eye health exam (i.e. regular eye exams for glasses and contacts) when no medical eye problem or related complaint specifically exists. Medical Insurance provides benefits for treatment of medical conditions related to the eye and/or health issues that can affect the eye. Symptoms or complaints such as eye disease, eye injury, or chronic medical condition (allergies) must be billed to medical insurance. **Although the examination that you received may be the same or similar to previous visits, the reason for the exam and the doctor's diagnosis dictate how we must bill our patients.** If you have a medical concern such as cataracts, blurry or dry eyes, allergy or any medical diagnosis your **medical** insurance must be billed.

Please Circle: Agree Disagree

Patient Signature____**Date**_______________

Parent/Guardian Signature (if pt is under 18)____________________________________**Date:**_______________

Name____Date___________________________________

Please circle any that you have or are experiencing. If none apply to you, please leave blank.

OCULAR HISTORY: Flashing lights Floaters Itching Watering Burning Crusting Glaucoma Cataracts
Other: ____

MEDICAL HISTORY: High Blood Pressure Type I Diabetes Type II Diabetes Headaches High Cholesterol Arthritis
Hyper/Hypothyroid Cancer Heart Disease Other: ____

SURGICAL HISTORY: Heart Brain Liver Spinal/Back Full Hysterectomy Partial Hysterectomy Thyroid
Glaucoma Cataract Other: ____

SOCIAL HISTORY: Smoke Drink Alcohol Use Illegal Drugs

HAVE YOU EVER HAD: A Blood Transfusion A Sexually Transmitted Disease

ARE YOU PREGNANT OR NURSING? YES NO

Do any immediate family members (current or past) have any of the following (please state whom below):

Diabetes_____________ High Blood Pressure_______________Heart Disease______________Cancer______________
Thyroid Disease______________Cholesterol____________Cataracts__________________Glaucoma______________
Macular Degeneration_________________Other____

ALLERGY / DRY EYE SYMPTOM CHECKLIST:

If you experience any of the following symptoms you may be suffering from ocular allergies or dry eye disease. These problems are both easily treatable. Please circle the number that best describes how you feel.

0=no problem 1=occasional problem 2=mild problem 3=moderate problem 4=severe problem 5=I am about to die

My eyes are red……………………………………………………………	0	1	2	3	4	5
My eyes itch……………………………………………………………….	0	1	2	3	4	5
My eyes water……………………………………………………………...	0	1	2	3	4	5
My eyes are crusty in the morning………………………………………....	0	1	2	3	4	5
My eyes swell overnight…………………………………………………...	0	1	2	3	4	5
My eyes feel gritty or sandy……………………………...……………...	0	1	2	3	4	5
My eyes burn……………………………………………...…………….	0	1	2	3	4	5
My eyes tear……………………………………………...………..…..	0	1	2	3	4	5

Primary Care Physician:_____________________________**Pharmacy:**_____________________________

Please list all current medications below. If you have a pre-populated list, please give it to the front desk receptionist and we will make a copy to attach to your record.

Allergies/Reaction:____

Medication / Strength **Reason for Taking**

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