Heritage Vision Center

Welcome to Heritage Vision Center

Salutation ☐ **Mr.** ☐ **Mrs.** ☐ **Miss** ☐ **Ms.** **Please Print**

Name____________________________________**Age**______**Date of Birth**____/____/____ **Sex:** ☐ **M** ☐ **F**

Address____

City_________________________________**State**_______________**Zip**___________________________

Email Address____

Home Phone #_______________________________**Work Phone #**______________________________

Social Security #_________________________ **Marital Status:** ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed**

Spouse Name____

Employer____**Phone #**__________________________
Occupation____________________________**Sports or Hobbies:**___________________________
In case of an emergency, whom should we contact?_____________________________________
Emergency Contact Phone #__________________________**Relation**_________________________
How did you hear about us?
☐ **Doctor (name)**____

☐ **Heritage Patient Referral (name)**_______________________________________
☐ **Internet** ☐ **Yellow Pages** ☐ **Insurance** ☐ **Other**
Have you or any of your blood relatives ever been told you have:(write "S" for Self, "R" for Relative)

Cataract ____ **Glaucoma** ____**High Blood Pressure** ____**Diabetes** ____ **Macular Degeneration** ____

Do you wear: **Prescription glasses?** ☐ **All the time** ☐ **Sometimes** ☐ **Not really**

Reading Glasses? ☐ **All the time for close up** ☐ **Sometimes** ☐ **No**

Contact Lenses? ☐ **Yes. Hard or Soft** ☐ **Occasionally** ☐ **No**
If you wear contacts presently. What brand?____
It would be helpful if you could tell us the prescription **RT:** ______________________________
LT: ______________________________
Do you have interest in: ☐ **New Prescription Glasses** ☐ **Contact Lenses** ☐ **Refractive Surgery Options**

List any allergies to medications: ____
Any medical conditions you are being treated for? ____________________________________
Tell us the medications you are currently taking: ____________________________________

____

Eye History

Circle "Yes" to indicate if you have any of the following:

Bloodshot Eyes	Yes	Floaters or Spots	Yes
Blurred Vision Distance	Yes	Glaucoma	Yes
Blurred vision Near	Yes	Headaches	Yes
Burning Eyes	Yes	Itching Eyes	Yes
Cataracts	Yes	Light Sensitive	Yes
Color Vision Poor	Yes	Loss of Vision	Yes
Crossed Eyes	Yes	Migraine Headaches	Yes
Discharge From Eyes	Yes	Night Vision Poor	Yes
Dizzy Spells	Yes	Red Eyes	Yes
Double Vision	Yes	Seeing Halos	Yes
Dry Eyes	Yes	Seeing Flashes	Yes
Eye Infection	Yes	Temporary Loss of Vision	Yes
Eye Strain	Yes	Twitching Eyelid	Yes
Fainting Spells	Yes	Vision Poor	Yes
Blackouts	Yes	Watering Eyes	Yes
Eye Injury	Yes	Latex Allergy	Yes

Health History

Circle "Yes" if you have any of the following:

AIDS or HIV+	Yes	Hepatitis A B C D	Yes
Arthritis	Yes	High Blood Pressure	Yes
Artificial Heart Valve	Yes	Kidney Disease	Yes
Artificial Joints	Yes	Lazy Eye	Yes
Asthma	Yes	Lupus	Yes
Bleeding	Yes	Migraine Headaches	Yes
Blindness	Yes	Pacemaker	Yes
Cancer	Yes	Poor Color Vision	Yes
Cataracts	Yes	Retinal Disease	Yes
Chemical Dependency	Yes	Rheumatic Fever	Yes
Diabetes	Yes	Shingles	Yes
Drug Sensitivity	Yes	Skin Conditions	Yes
Emphysema	Yes	Stroke	Yes
Epilepsy	Yes	Thyroid Conditions	Yes
Eye Surgery	Yes	Tuberculosis	Yes
Heart Condition	Yes	Turned Eye	Yes
Hay Fever	Yes		

Are you pregnant? Yes No **Breast Feeding?** Yes No

Tobacco Use? Yes No **Alcohol Use?** Yes No

Have you ever passed out during a medical procedure, dental procedure, or giving blood? Yes No

Patient Name: ____

Date: ______________________________________

Except medical emergency, payment is required at the time of service. We will be happy to assist you with any insurance you may have. **Please indicate your form of payment today (please check one):**

____ Cash ____ Personal Check ____ Visa/Master Card/American Express/Discover

Signature ____ Date __________________________

Insurance: List your primary insurance company first.

The Front Office will need copies of current insurance cards in order to process your insurance claim properly.

Name of Primary Carrier: ____

Name of Insured ____

Date of Birth _________________________ Social Security # _________________________________

Policy # ____ Group # ______________________

Secondary: ____

Name of Insured ____

Date of Birth ________________________ Social Security # __________________________________

Policy # ____ Group # ______________________

In signing below, I authorize any medical or other information about me needed for proper processing of any claim to be released to Medicare or Commercial insurance companies or to their intermediaries. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to me or to the party who accepts assignment. I understand that it is my responsibility to verify benefits and coverage for any services performed and that I will be personally responsible if my insurance does not pay within 90 days after the claim is submitted.

Signature ____ Date ______________________

Patient Name: ____

Date: __________________________________

Patient Acknowledgement of Notice of Privacy Practices

As Required by the Standards of the Health Insurance portability and Accountability Act of 1996 (HIPPA)

I have received a copy of the Notice of Privacy Practices of Heritage Vision Center on the date indicated below.

I understand that if any changes are made to this Notice of Privacy Practices, a revised copy of the Notice will be posted in the office of Heritage Vision Center.

I also understand that if I wish to receive additional copies of this Notice of Privacy Practices in the future or if I have any questions with regard to this Notice of Privacy Practices, I may contact Heritage Vision Center.

Patient Consent For Use And Disclosure Of Protected Health Information

I hereby give my consent for Heritage Vision Center to use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Heritage Vision Center Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Heritage Vision Center reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of privacy practices may be obtained by forwarding a written request to:

Heritage Vision Center
Attention: Compliance Officer
2427 Heritage Village, Ste. 4
Snellville, GA 30078
770-978-2020
FAX: 770-978-1750

With this consent, Heritage Vision Center may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any calls pertaining to my clinical care.

With this consent, Heritage Vision Center may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements.

With this consent, Heritage Vision Center may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements.

I have the right to request that Heritage Vision Center restricts how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to heritage Vision Center's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Heritage Vision Center may decline to provide treatment to me.

____________________________	____________________________	______________
Signature of Patient or Legal Guardian	**Print Name of Patient or Legal Guardian**	**Date**