Welcome to Briarwood Vision Center

Please answer the following questions to help us treat you better

Patient Information:

Name: Last_____________________ First_________________Today's Date___________ Sex: M F
Address:____________________________________City:_________________ State: ____Zip_______
Phone: best number to contact you( )_______________ Date of Birth:______________ Age:______
Email address:_____________________May we remind you of your annual exam via e-mail? Yes No

Personal Information:

Have you been examined here before?_____ How did you hear about our office?___________________
Occupation____________________What sports and hobbies do you enjoy?_______________________
How much of your day do you spend working on a computer?__________________________________
Do you know anyone else who could use our services? If so, whom?_____________________________

Ocular and Medical History:

Reason for today's visit:____________________________________Date of last eye exam:_________
age of present glasses:________Have you ever worn contacts before?_____If not currently wearing contacts, are you interested in trying contacts?_______ what lens care system do you use?___________
Have your eyes ever been dilated……………………………… Yes No Date:___________________
Have you ever had an eye infection, disease, injury or surgery?. Yes No Explain:________________
Are you sensitive to bright lights?.. Yes No
Do you see and flashes of light or floaters?................................ Yes No
Do you have trouble with night vision?..................................... Yes No
Are you experiencing any of the following with your eyes?(circle) Contact lens intolerance
Itchiness stinging burning dryness redness

Do <u>you or any blood relatives</u> have any of the following?
Diabetes………………………………………………………… Yes No Whom________type______
Date of Diagnosis________
High blood pressure:…………………………………………… Yes No Whom_________________
Thyroid condition……………………………………………….. Yes No Whom_________________
Cataracts……………………………………………………… Yes No Whom_________________
Glaucoma…………………………………………………….. Yes No Whom_________________
Retinal detachment or degeneration:…………………………….. Yes No Whom_________________
Macular degeneration…………………………………………. Yes No Whom_________________
Other eye conditions………………………………………………Yes No Explain________________

Who is your primary care physician?________________________________
How is your general health?____
Are you currently pregnant?________if so, how far along?_________

Do you smoke?__________________if so, how much?____________
Do you have any allergies?____
Please list any medications you are currently taking and their purpose:
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Financial Agreement: All charges for services and treatment will be paid upon completion of the appointment. All delinquent balances after 30 days will be turned over to a collections agency.

Insurance Billing: It is the policy of this office that all charges, regardless of insurance coverage, are ultimately the responsibility of the patient. Please understand that is for any reason payment is denied by your listed insurance company, we will seek compensation from the individual patient.

Co-payments: Your co-payment, deductibles, or charges over the maximum benefit amount allowed by the insurance company is due at the time of service.

I understand that my insurance company may not fully reimburse the doctor's fees for the services provided. Any benefits or pre-authorizations given to this office are not a guarantee of payment by the insurance company. Payment is dependent of eligibility at the time of service and all the terms and conditions of the plan. By my signature on this form, I agree that I am financially responsible for any balance owed for the doctor's services or materials which are not covered through my insurance.

Patient or Guardian's signature_____________________________________ Date _______________