ALASKA VISION CENTER, INC.

Jill Geering Matheson, OD Sarah Bixby-DuBois, OD

800 Glacier Avenue Juneau AK 99801 (907) 586-9864 FAX (907) 463-2679

PATIENT INFORMATION DATE: _____

LAST NAME: _____ FIRST NAME: _____ M.I.: _____

ADDRESS: _____ HOME PHONE: _____

CITY/STATE/ZIP: _____ WORK PHONE: _____

BIRTH DATE: _____ SEX: _____ SSN: _____ CELL PHONE: _____

EMAIL ADDRESS: _____

OCCUPATION: _____

IF MINOR CHILD, MOTHER'S NAME: _____ DAY PHONE: _____

FATHER'S NAME: _____ DAY PHONE: _____

IN CASE OF EMERGENCY, PLEASE NOTIFY: _____ PHONE: _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

Is this person a patient of Alaska Vision Center? _____ Yes _____ No

BILLING INFORMATION

PERSON RESPONSIBLE FOR ACCOUNT (IF NOT PATIENT): _____

ADDRESS: _____ PHONE: _____

INSURANCE INFORMATION IS YOUR VISION COVERAGE VSP (VISION SERVICE PLAN)? ☐ YES ☐ NO

MEMBER NAME/BIRTHDATE: _____ Soc. Sec. # _____

CARRIER: _____ ADDRESS: _____

PHONE: _____ MEMBER ID#: _____ Group # _____

Member relation to patient: Self Spouse Parent Other

Is this coverage MEDICAL ONLY MEDICAL/VISION

By signing below, I certify that I (or my dependent) have insurance coverage as stated above and assign all insurance benefits otherwise payable to me to the doctors. I understand that I am financially responsible for all charges whether paid by insurance or not, and Alaska Vision Center is not responsible for determining benefits or eligibility. I hereby authorize the doctors to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

SIGNATURE: _____ DATE: _____

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made on my behalf to this office for any services furnished me. I authorize any holder of medical information about me to release to Health Care Financing Administration, its agents, and my supplemental carrier 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. 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 only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

SIGNATURE: _____ DATE: _____

PATIENT NAME: _____ DATE: _____

PLEASE LIST MAIN REASON FOR COMING IN TODAY: _____

DATE OF LAST EYE EXAM: _____ BY WHOM? _____ DILATED? Y N

DO YOU WEAR: GLASSES? Y N circle: Distance Reading Progressive Other: _____

CONTACT LENSES? Y N circle: Soft Hard/RGP Remove nightly? Y N How often do you replace? _____

ARE YOU INTERESTED IN CONTACT LENSES TODAY? Y N NEW GLASSES TODAY? Y N

DOES YOUR VISION BLUR FOR THE FOLLOWING (**WITH** YOUR GLASSES OR CONTACTS IF YOU WEAR THEM)?

DISTANCE VIEWING Y N COMMENTS _____

NEAR VIEWING Y N COMMENTS _____

ARM'S LENGTH VIEWING Y N COMMENTS _____

DO YOU SEE DOUBLE? Y N COMMENTS _____

HEADACHES? Y N TIME OF DAY: _____ MIGRAINES? Y N

WHAT PART OF HEAD: _____ HOW OFTEN _____

DO YOUR EYES:

ACHE? Y N BURN? Y N TIRE/STRAIN? Y N

ITCH? Y N WATER? Y N PLEASE EXPLAIN: _____

EYE HISTORY:

HAVE YOU HAD ANY EYE OPERATIONS: LIST/WHEN: _____

HAVE YOU HAD ANY EYE INJURIES: LIST/WHEN: _____

DO YOU OR ANY FAMILY MEMBER HAVE:	**SELF**:	**FAMILY MEMBER:**
GLAUCOMA?	Y N	RELATION: _____
CATARACTS?	Y N	RELATION: _____
DRY EYES?	Y N	RELATION: _____
MACULAR DEGENERATION?	Y N	RELATION: _____
CROSSED EYE: circle: R L and In Out Vertical	Y N	RELATION: _____
LAZY EYE/AMBLYOPIA? Circle: R L	Y N	RELATION: _____

DO YOU SEE: FLASHES OF LIGHT? Y N COMMENTS: _____

FLOATERS? Y N COMMENTS: _____

ANY OTHER EYE PROBLEMS? PLEASE LIST: _____

MEDICAL HISTORY

DO **YOU** HAVE ANY OF THE FOLLOWING?

ARTHRITIS	Y N	ASTHMA	Y N	BLEEDING DISORDER	Y N
CANCER	Y N	DIABETES	Y N	RESPIRATORY DISORDER	Y N
EPILEPSY	Y N	HAY FEVER	Y N	HEART CONDITION	Y N
HEPATITIS (TYPE___)	Y N	HYPERTENTION	Y N	KIDNEY DISEASE	Y N
LUPUS	Y N	MIGRAINES	Y N	SHINGLES	Y N
SKIN CONDITIONS	Y N	STROKE	Y N	THYROID CONDITION	Y N
TUBERCULOSIS	Y N	AIDS/HIV	Y N	SINUS PROBLEM	Y N
HIGH CHOLESTEROL	Y N	TOBACCO USE	Y N	PREGNANT	Y N
SLEEP DISORDER	Y N	CROHN'S/IBS	Y N	BACK/NECK ISSUES	Y N
DEPRESSION	Y N	PROSTATE PROB	Y N	OTHER PSYCHIATRIC DIS.	Y N

ANY OTHER HEALTH PROBLEMS? _____

_____

IF YOU ARE DIABETIC: TYPE: 1 or 2 YEAR DIAGNOSED: ____LAST A1C:____WHEN?_____GLUCOSE:_____

PLEASE DESCRIBE ANY YES ANSWER ABOVE: _____

_____

ARE YOU TAKING ANY **MEDICATIONS**? PLEASE LIST: _____

_____

ARE YOU USING ANY **EYEDROPS OR ORAL MEDICATION FOR YOUR EYES**? Y N

IF YES, PLEASE LIST: _____ HOW OFTEN? _____

HAVE YOU HAD ANY OPERATIONS? TYPE _____ DATE _____

MEDICATION ALLERGIES: Y N TO WHAT? _____ WHAT HAPPENS? _____

OTHER ALLERGIES: _____

NAME OF FAMILY DOCTOR: _____ DATE OF LAST VISIT? _____

DOES ANYONE **IN YOUR FAMILY** HAVE:

HIGH BLOOD PRESSURE: Y N RELATION _____

DIABETES: Y N RELATION _____

Other health disorders in your family: _____

PATIENT SIGNATURE (PARENT/ GUARDIAN SIGNATURE REQUIRED IF PATIENT IS UNDER 18): _____