# 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: _____ AGE: _____ 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: _____
ADDRESS/PHONE: _____
EMPLOYER: _____ EMPLOYER ADDRESS _____

**INSURANCE INFORMATION** IS YOUR VISION COVERAGE VSP (VISION SERVICE PLAN)?: ☐ YES ☐ NO
CARRIER: _____ ADDRESS: _____
PHONE: _____ SUBSCRIBER ID#: _____
SUBSCRIBER: _____ RELATION TO PATIENT: _____
GROUP NAME: _____ GROUP #: _____
IS THIS COVERAGE MEDICAL ONLY OR MEDICAL/VISION BOTH? _____
IN CERTAIN INSTANCES, WE WILL BILL SECONDARY INSURANCE AND/OR YOUR SUPPLEMENTAL INSURANCE. PLEASE ASK OUR STAFF.

*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 or not paid by insurance. 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: _____

## PATIENT EYE/VISION HISTORY

DATE OF LAST EYE EXAM: _____ BY WHOM? _____ DILATED? Y N
DO YOU WEAR GLASSES: Y N WHAT KIND: _____
DO YOU WEAR CONTACT LENSES? Y N WHAT KIND: _____
ARE YOU INTERESTED IN CONTACT LENSES 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 YOU USE A COMPUTER: Y N HOURS PER DAY: _____
DO YOUR EYES:
ACHE? Y N BURN?: Y N TIRE/STRAIN? Y N
ITCH? Y N WATER? Y N PLEASE EXPLAIN: _____
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/LAZY EYE? | Y | N | RELATION: _____ |
| DO YOU SEE: FLASHES OF LIGHT? | Y | N | COMMENTS: _____ |
| FLOATERS? | Y | N | COMMENTS: _____ |

ANY OTHER EYE PROBLEMS? PLEASE LIST: _____
ARE YOU USING ANY EYEDROPS OR ORAL MEDICAION FOR YOUR EYES? Y N
IF YES, PLEASE LIST: _____ HOW OFTEN? _____
PLEASE LIST MAIN REASON FOR COMING IN TODAY: _____

## PATIENT MEDICAL HISTORY

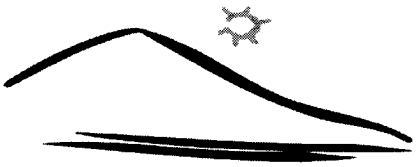
DOES ANYONE IN YOUR FAMILY HAVE:
HIGH BLOOD PRESURE: Y N RELATION _____
DIABETES: Y N RELATION _____

DO YOU HAVE ANY OF THE FOLLOWING PROBLEMS?

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| ARTHRITIS | Y | N | ASTHMA | Y | N | BLEEDING DISORDER | Y N |
| CANCER | Y | N | DIABETES | Y | N | EMPHYSEMA | 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 |

PLEASE DESCRIBE ANY YES ANSWER (ABOVE): _____
_____
IF YOU ARE DIABETIC, PLEASE LIST TYPE _____ DIAGNOSIS DATE _____
ANY OTHER HEALTH PROBLEMS? _____
_____
ARE YOU TAKING ANY MEDICATIONS? PLEASE LIST: _____
_____
HAVE YOU HAD ANY OPERATIONS? TYPE _____ DATE _____
ALLERGIES Y N TO WHAT? _____ WHAT HAPPENS? _____
NAME OF FAMILY DOCTOR: _____ DATE OF LAST VISIT? _____
DATE OF LAST TETANUS SHOT: _____ DO YOU SMOKE? Y N

PATIENT/GUARDIAN (IF UNDER 18) SIGNATURE: _____



**ALASKA VISION CENTER, INC.**

VISION SOURCE™

DR. JILL GEERING MATHESON
DR. SARAH BIXBY-DUBOIS
OPTOMETRISTS

# RECORDS RELEASE REQUEST FORM

***NAME OF PATIENT:*** _____

***BIRTHDATE:*** ____/____/____

***I HEREBY AUTHORIZE DR:*** _____

***AT:*** _____

***TO RELEASE MY RECORDS TO DR:*** _____

***AT:*** _____

***SIGNATURE:*** _____
***(Parent/Guardian if patient under 18 years of age)***

***DATE SIGNED:*** ____/____/____

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