

WELCOME, THANK YOU FOR CHOOSING DR. JONES' VISION SOURCE OFFICE.

PLEASE PRINT CLEARLY ON BOTH SIDES AND SIGN DATE: _____

Last Name _____ First Name _____ MI _____

Address _____ Apt _____ City/State _____ Zip _____

Home phone _____ Work Phone _____ Cell Phone _____

Email Address _____

Sex: M F Date of Birth _____ Marital Status: Single Married Divorced Widow(er)

Social Security Number _____

Occupation _____ Employer _____

Referred by _____

Emergency Contact _____ Phone Number _____

PRIMARY INSURANCE MEMBER / PERSON RESPONSIBLE FOR PAYMENT – IF OTHER THAN SELF:

Last Name _____ First Name _____ MI _____

Address _____ Apt _____ City/State _____ Zip _____

Home phone _____ Work Phone _____ Cell Phone _____

Email Address _____

Sex: M F Date of Birth _____

Social Security Number _____

Relationship to Patient _____

VISION / MEDICAL INSURANCE INFORMATION

Vision Insurance _____ ID Number _____

Member's Name _____ Relation: Self Spouse Child Other

Medical Insurance _____ ID Number _____

Member's Name _____ Relation: Self Spouse Child Other

Secondary Insurance _____

I'm interested in: _____ Glasses _____ Contact Lenses _____ Laser Correction Surgery

I have a back up pair of glasses: Yes No

Current vision correction: _____ Glasses _____ Contact Lenses _____ Laser/Refractive Surgery

IS THERE A SPECIFIC REASON FOR YOUR VISIT? _____

General Health _____ **Last Eye Exam** _____ **Eyes Dilated? Yes No**

History	Personal	Family	History	Personal	Family	History	Personal	Family
Arthritis	Y	N	Kidney Disease	Y	N	Glaucoma	Y	N
Asthma	Y	N	Thyroid Disease	Y	N	Retinal Detachment	Y	N
Respiratory	Y	N	Anxiety	Y	N	Macular Degeneration	Y	N
Herpes	Y	N	Hypertension	Y	N	Cataracts	Y	N
HIV	Y	N	Hepatitis	Y	N	Dry Eyes	Y	N
Heart Attack	Y	N	Stroke	Y	N	Headaches	Y	N
Cancer	Y	N	Diabetes	Y	N	Blurred Vision	Y	N
If yes, type of cancer: _____						Cholesterol	Y	N

Allergies Yes No (list) including any allergies to medicine _____

Other health problems _____

List any medications you are taking (including oral contraceptives, aspirin, over the counter medications and vitamins) if not taking any write None _____

Are you pregnant and/or nursing? Yes No

Have you had any eye operations including laser eye correction (such as Lasik) Yes No

Date/Type _____

Have you had an eye injury? Yes No

Date/Type _____

Do you use? Cigarettes/Tobacco Yes No Alcohol Yes No Other Substances Yes No

Primary Care Doctor/Provider _____ Date of last visit _____

I understand that payment for the goods or services I will receive is expected at the time that they are rendered. A deposit, if unable to make full payment, is required for glasses or contact lenses ordered. Any order cancellations done after completion of the job will result in the loss of deposit. Any materials not dispensed within 90 days of completion and notification may be returned to stock and are subject to loss of deposit. Eyeglass orders cancelled before lens fabrication has begun are entitled to a refund of the applicable deposit less all co-pays plus a \$20.00 fee.

I, _____ hereby, agree to be financially responsible for all charges incurred over and above the amount allotted by insurance coverage. In the event my account is referred to a collection service due to the lack of payment on my part, I agree to pay all collection agency/legal fees that may be added to my account.

Returned checks: A \$25.00 NSF fee will be charged for checks initially returned unpaid by your bank. If the same check is returned unpaid a second time, it may be referred to a collection service for recovery.

I have read and understand all the above conditions, and agree to their terms.

I acknowledge that I have received a copy of the **Notice of Privacy Practices** for the office of Michael D. Jones, O.D., Inc.

Insurance Signature on File: I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping obtain payment of my insurance and/or Medicare benefits, and I authorize payment of these benefits directly to Michael D. Jones, O.D., Inc. on my behalf for any services and materials furnished. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits payable to related services. If I have other health insurance coverage (as indicated in item 9 or the CMS-1500 claim form or electronically submitted claim.) my signature authorizes release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as my agent as above. I will be responsible for any co-payments and payments for non-covered services.

Signature _____

(Parent or Guardian if under 18)

Date _____