PLEASE PROVIDE US WITH YOUR PHOTO ID, AND any insurance cards!

First Name_____**Last Name**_____**Middle**_____

Address_____City_____State_____Zip_____

Phone # for Contact_____Date of Birth___/___/___Email: _____

Occupation:_____

I have the following hobbies:_____

HEALTH QUESTIONS

Do you have a **HISTORY** of the Following?

☐ High Blood Pressure ☐ Diabetes

☐ Other Medical Conditions: (Explain) _____

_____

☐ Eye Disease: (Explain) _____

_____

Do you have a **FAMILY** history of the following?

☐ High Blood Pressure ☐ Diabetes ☐ Glaucoma

☐ Eye Disease: (Explain) _____

_____

Who is your Primary Care Physician? _____

_____

Please list any current medications: ☐ None _____

_____

_____

Please list any medications you are allergic to:

☐ None _____

_____

If Female, are you pregnant or nursing?

◯ Yes, how far along?_____ ◯ No

Do you have **MEDICAL** insurance? ◯ Yes *or* ◯ No

Insurance Company Name: _____

ID#_____

DOB: _____

Name of Insured: _____

Employer of Insured: _____

EYE QUESTIONS

I Currently wear: ☐ Glasses ☐ Contacts ☐ No Correction

I Struggle with: ☐ Glare or Halos around lights

☐ Headaches ☐ Poor Night Vision ☐ Eyestrain/Tired Eyes

Blurred Vision At:

☐ Far ☐ middle/computer - **or**- ☐ close distances

When was your last Eye Exam? (Year) _____

Where? _____

Do you have **VISION** insurance? ◯ Yes *or* ◯ No

Insurance Company Name:_____

ID# _____

DOB: _____

Name of Insured: _____

Employer of Insured: _____

It may be necessary to enlarge the pupil of the eye (dilation) to more thoroughly examine the inside health of the eye. These drops may cause light sensitivity, blurred vision when reading, and sometimes make driving difficult.

May the doctor dilate your eyes today?

◯ *Yes* ◯ *No,* ***I decline dilation today.***

GEAUGA VISION

Initial please _____

You are receiving a $25 discount for paying in full on the day of service. If you have a high deductible insurance plan or suspect that your insurance may not pay, please let us know.

I authorize the release of any medical/other information necessary to process claims arising from the services provided. I assume all financial responsibility for this account and all amounts due regardless of insurance coverage.
I have read and understand the (HIPPA) health information personal privacy act.

Signature: _____ **Date**:_____ **Relationship**: _____

No change (please initial & date) _____ ___/___/___ _____ ___/___/___ _____ ___/___/___ _____ ___/___/___

_____ ___/___/___ _____ ___/___/___ _____ ___/___/___ _____ ___/___/___

Medical (For Office Use Only)

☐ 99202 ☐ 99212 ☐ 99203 ☐ 99213 ☐ 99204 ☐ 99214

Routine

☐ 92004 ☐ 92014 ☐ 92015 ☐ 92310 $_____

DX CODES

☐ DM	MYOPIA	HYPEROPIA	ASTIG	PRESBOPYIA
☐ DM w Ret	☐ H52.11	☐ H52.01	☐ H52.221	☐ H52.4
☐ High Chol	☐ H52.12	☐ H52.02	☐ H52.222	
☐ HTN	☐ H52.13	☐ H52.03	☐ H52.223	