Welcome to
Family Vision Center

4601 Telephone Road, Suite 109, Ventura, California ● Phone: 805-642-4185 ● Fax: 805-642-4416
www.fvcventura.com

Thank you for choosing us, please take a moment to complete this form.

Patient Name: _____DOB:_____ SSN:_____

Address:_____City:_____State:_____ Zip:_____

Responsible Party Name:_____ (Mother/Father) Same Address: Y/N

Home Phone: _____ Work/Cell Phone: _____ **Email**_____

☐ Married ☐ Single ☐ Other Pharmacy you prefer to use: _____

Who may we thank for referring you to our office?_____

Primary Care Doctor:_____

__ (Initials) Contact lenses require additional testing and evaluation, thus there is an additional fee for our contact lens patients. Our fee for these services ranges from $40 to $100 depending upon your prescription. We will notify you of your exact fee before we provide the service.

Current Medications:_____

Allergies to Medications: Y/N If yes, which medications?_____

Height:_____ Weight: _____

.

The following pertains to your visual symptoms and health history. Please check all that apply.

VISION: □Infections □Injuries □Distance vision blurry □Headaches □I wear bifocals (or progressive)
□Lazy eye □Glaucoma □Near vision blurry □Macular Degeneration □Eye surgeries
□Dry eyes □Flashing lights □Floating spots □I wear contact lenses

IMMUNOLOGIC: ☐Rheumatoid arthritis ☐Lupus ☐Other

CARDIOVASCULAR: ☐High blood pressure(Hypertension) ☐ Arrhythmia ☐Other

RESPIRATORY: ☐Tobacco user/Smoker ☐Asthma ☐Emphysema ☐Other

MUSCLES,BONES,JOINTS: ☐Arthritis ☐Fibromyalgia ☐Osteoarthritis ☐Ankylosing spondylitis ☐Other

SKIN: ☐Rash ☐Cancer

NEUROLOGIC: ☐Seizures ☐Headaches ☐Other

PSYCHIATRIC: ☐Depression ☐Schizophrenia ☐Other

ENDOCRINE: ☐Diabetes Type _____ ☐Hyperthyroid ☐Hypothyroid
If diabetic, last HgA1c:_____ and last blood sugar:_____

HEMATOLOGIC: ☐Anemia ☐Leukemia ☐High Cholesterol ☐Other

ALLERGIC: ☐Seasonal ☐Itching ☐Swelling

FAMILY HISTORY:
☐ Glaucoma
☐ Diabetes
☐ Macular degeneration

INSURANCE INFORMATION

Vision Insurance: _____ Primary Insured's Name: _____

Insured's Date of Birth (mm/dd/yr): _____ Insurance ID #: _____

Medical Insurance: _____ Primary Insured's Name: _____

Insured's Date of Birth (mm/dd/yr): _____ Insurance ID#: _____

CONSENT AND AUTHORIZATION

I acknowledge and understand that I am responsible for all of the charges for services and materials rendered to me or to the person named above for which I am responsible. I further understand that the billing to my insurance company or Medicare in no way relieves me of responsibility for payments, co-payments or payments for non-covered services and materials due to Family Vision Center. I understand that delinquent balances are subject to finance charges and that the account may be sent to a collections agency. I hereby authorize my insurance company to pay proceeds for any benefits otherwise due to me directly to Family Vision Center. _____ initial

I authorize the release of any medical information, by electronic or other means, to process insurance claims, or for use in medical research. I understand by signing this form I am allowing my medical information to be released to my insurance company, primary care physician and specialists for the purpose of health care operations or medical research, as described in our *Notice of Privacy Practices.* I understand that I may revoke this consent by written request at any time.
_____ initial

ASSIGNMENT OF MEDICARE BENEFITS

(if applicable)

Family Vision Center is a Medicare participating provider. Therefore, we will bill Medicare directly. Medicare will send payment directly to our office. This payment will consist of 80% of the Medicare Part B approved charges. I understand that I will be responsible for the yearly deductible and 20% of approved charges. I have been informed that not all services are covered by Medicare (e.g. eye refractions).

My signature below further verifies that I have not joined an HMO or other entity in which my Medicare benefits have been relinquished ____ initial

Acknowledgement of Receipt of HIPPA Notice of Privacy Practices

If you are already familiar with the Patient Information Confidentiality Laws (HIPPA), please sign below and return to receptionist. If you are unfamiliar with our confidentiality practices or would like a copy to review or take with you, please feel free to ask the receptionist for more information.

Printed Patient Name:_____ Date: _____

Signature of Patient or Responsible Party: _____