Ford Vision Clinic Patient Data Sheet

Last Name: ______________________________________ **Date of Birth: _______________________**

First Name: ______________________________________ **Middle Initial: ______________________**

Address: ____

City: ___________________________________ **State: _____________** **Zip Code: ________**

Gender: ________________________________ **Race: ____________________________________**

Marital Status: __________________________ **Employment Status: _______________________**

Employer: ______________________________ **Occupation: ______________________________**

Home Phone: ___________________________ **Day Phone: _______________________________**

Cell Phone: _____________________________ **Social Security #: __________________________**

E-Mail Address: ____

Insurance: ______________________________ **Policy Holder: _____________________________**

Policy Holder's Date of Birth: _______________ **Policy Holder's SSN#: ______________________**

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Privacy Policy

In order to ensure compliance with Health Care Information Portability and Accessibility Act of 1996 **(HIPPA)**, this practice has established a privacy policy to provide for the security of your medical records.

All patient records shall be stored on an encrypted computer system with access restricted to qualified personnel.

No patient information shall be shared with another health care provider without the patient's written, signed consent with the exception of a medical emergency where the patient's life may be compromised without said information.

No patient information, including but not limited to medical information, demographic information, lifestyle information, and financial information shall be released for the purpose of marketing outside of the practice.

This Practice uses appointment reminders, text messages, as well as telephone calls to help the patient preserve both their ocular and general health. If you do not wish to receive these appointment reminders, please notify the front desk clerk.

Any and all computer terminals containing patient information are secured by password protection with only qualified staff possessing a password to access the computer systems.

If you have any questions or concerns about your privacy and your medical records, please do not hesitate to ask the doctor or our staff members.

Signature: ____ **Date: _________________________**

(Patient Signature, Parent or Guardian if patient is a minor)

Please list all current medications below. If you have a prepopulated list, please give it to the front desk receptionist and we will make a copy to attach to your record.

Allergies/Reaction:____

Primary Care Physician:____

Pharmacy:____

Medication	Strength	How to use	Reason for taking
________________________	_______________	________________________	______________________________
________________________	_______________	________________________	______________________________
________________________	_______________	________________________	______________________________
________________________	_______________	________________________	______________________________
________________________	_______________	________________________	______________________________

GRAY AREAS ARE ABOUT THE PATIENT

Please circle any that you have or are experiencing if none apply to you please leave blank.

OCULAR HISTORY: Flashing lights Floaters Itching Watering Burning
Crusting Glaucoma Cataracts Other: _____

MEDICAL HISTORY: High Blood Pressure Diabetes Headaches High Cholesterol Arthritis
Hyper/Hypothyroid Cancer Heart Disease Other: _____

SURGICAL HISTORY: Heart Brain Liver Spinal/Back Hysterectomy Full/Partial
Cataract Glaucoma Thyroid Other: _____

SOCIAL HISTORY (do you do any of the following): Smoke Drink Alcohol Abuse Drugs Use Illegal Drugs
(Have you ever had): A Blood Transfusion A Sexually Transmitted Disease

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If anyone in your family has/had any of the following, **PLEASE WRITE BESIDE THE CONDITION WHO HAS/HAD THESE (**DAD, MOTHER, GRANDFATHER, GRANDMOTHER, AUNT, UNCLE, ETC**.)**

Diabetes_____ High Blood Pressure_____Heart Disease_____
Cancer_____Thyroid Disease_____Cholesterol_____
Cataracts_____Glaucoma_____Macular Degeneration_____
Other_____

ALLERGY SYMPTOM CHECKLIST:

If you experience any of the following symptoms you may be suffering from Ocular Allergies, an easily treatable problem. Please circle the number that best describes how you feel.

0=no problem 1=occasional problem 2=mild problem 3=moderate problem 4=severe problem 5=I am about to die

My eyes are red……..	0	1	2	3	4	5
My eyes itch……0	1	2	3	4	5	
My eyes water…….0	1	2	3	4	5	
My eyes are crusty in the morning……	0	1	2	3	4	5
My eyes swell overnight…….....	0	1	2	3	4	5

DRY EYE SYMPTOM CHECKLIST

If you experience any of the following symptoms you may be suffering from Dry Eye Syndrome, an easily treatable problem. Please circle the number that best describes how you feel.

0=no problem 1=occasional problem 2=mild problem 3=moderate problem 4=severe problem 5=I am about to die

My eyes feel gritty or sandy……	0	1	2	3	4	5
My eyes burn……...	0	1	2	3	4	5
My eyes tear……..……..	0	1	2	3	4	5
My eyes are uncomfortable in windy conditions……...….	0	1	2	3	4	5
My eyes are uncomfortable when the car A/C blows on them……...	0	1	2	3	4	5

READ CAREFULLY-VERY IMPORTANT

Insurance and Refraction Policy

We want your experience with Ford Vision Clinic to be as pleasant as possible and are happy to assist you with any insurance questions that you may have. Please read over the following. As a courtesy to our patients we will file insurance claims for all insurance plans in which we participate in. We are happy to file for you as long as you provide us with complete information prior to being seen by the Doctor. Failure to provide insurance cards-information before being called to exam room means that **YOU** are responsible for payment. Any charges not covered by your insurance are due at time of service unless other arrangements have been made ahead of time. You are responsible for any co-payments and deductible amounts or any non-covered services on the day services are rendered.

There are two types of insurance that cover eye care, Vision Insurance and Medical Insurance. Ford Vision Clinic must bill the appropriate insurance as legally directed. Vision Insurance covers your annual eye health exam (i.e. regular eye exams for glasses and contacts) when **NO** medical eye problem or related complaint specifically exists. Medical Insurance provides benefits for treatment of medical conditions related to the eye and/or health issues that can affect the eye. Symptoms or complaints such as eye disease, eye injury, or chronic medical condition (allergies) must be billed to medical insurance.

Although the examination that you received may be the same or similar to previous visits, the reason for the exam and the doctor's diagnosis dictate how we must bill our patients. If you have a medical concern such as cataracts, blurry or dry eyes, allergy or any medical diagnosis your **MEDICAL** insurance must be billed.

Refraction- a test generally used to determine your glasses or contact lens prescription. If you have a medical diagnosis, your visit must be billed to your medical insurance; unfortunately medical insurances DO NOT cover refractions. We are required by medical insurances to bill the patient for the service. As of April 1, 2018, the fee for this service will be $35.

I have read and understand the above policies of Ford Vision Clinic. Please indicate whether you agree or disagree.

___ Agree

___ Disagree

Signature: _____ **Date**: _____

DILATION CONSENT

It is our goal to provide a complete and thorough comprehensive eye examination. To effectively accomplish our goal, we feel it is important to dilate the pupils of your eyes. This will require placing drops in your eyes which will open the pupil and allow a better view of the inside of your eye.

As with many medications, there are some side effects of the drops used to dilate the pupil. These include sensitivity to light and blurred vision (in most cases the distance vision will be unaffected). The side effects usually last several hours but rarely last as long as 24 hours.

While we believe dilation is an important part of the eye examination process, we understand that some patients may wish to omit this procedure. There is no additional fee for this service. **Please indicate your preference below:**

☐ I wish to be dilated today

☐ I do not wish to be dilated and agree to hold Dr. Ford and Ford Vision Clinic harmless as a result of my actions.

Patient Signature Required: _____ Date: _____

Under 18 Guardian Signature Required: _____ Date: _____