ARKANSAS VISION DEVELOPEMENT CENTER

Adult Patient Information and Registration

Name (Last)_____(First)_____(Middle)_____Soc. Sec#_____
Sex: ____M____F Birth Date:_____ Email:_____ AKA:_____
Street Address:_____City:_____State:_____Zip:_____
Primary Number:_____Cell:_____Work:_____ext:_____

Additional Patient Data:

Marital Status:_____Single____Married____Widowed____Seperated____Divorced Student:____Yes____No
Race/Ethinicity (circle) White/Asian/Native Hawaiian/Other Pacific Islander/Black or African American/
American Indian or Alaskan Native/ Hispanic/Latino ***Lanquage:*** ___English___Spanish___Other

Guarantor Information: (Person Responsible for the account)

Name (Last)_____(First)_____(Middle)_____Soc. Sec#_____
Birth Date:_____Street Address:_____City:_____State:_____Zip:_____
Patient Relationship to Guarantor:___Self___Child___Parent___Spouse___Other

Primary Insurance:_____Holder Name:_____ DOB:_____SS:_____
Plan name:_____ID#:_____Group:_____
Patient Relationship to Holder: ____Self____Child____Other

Secondary Insurance:_____Holder Name:_____DOB:_____SS:_____
Plan name:_____ID#:_____Group:_____
Patient Relationship to Holder: ____Self____Child____Other

Other Family Members who are current Patients:

Name:_____ Name:_____

In case of an emergency, list who we may conact:

Contact Name:_____Phone#:_____Relation:_____
Contact Name:_____Phone#:_____Relation:_____

***********NOTICE FOR FILING OF INSURANCES**********

I understand that I am **financially responsible** for all services incurred today. This financial responsibility includes any deductible, co-insurance, non-covered services.

I agree that the insurance information given to you today is current and should I have out of network Primary and or Secondary insurance, that I am responsible for the cost of todays visit. I understand that payment is due at the time services are rendered, and that I am to furnish any and all explanation of benefits upon receipt of same to the doctor's office for filing of my secondary insurance, should it apply.

I HEREBY authorize release of medical information necessary to file a claim with my insurance with benefits made on my behalf to Dr. Wanda Vaughn for services rendered.

_____ _____
Patient or Responsible Party Signature Date

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Consent to Treatment:

I voluntarily consent to outpatient care which may encompass examination and medical or visual treatment, and administration of medications as ordered by the physician.

I understand the performance of examinations, diagnostic procedures, and rendering of treatment will be by the Physician. Other services my be rendered by their clinical assistants by direct order of the Physician.

I authorize the release of medical/treatment information to the insurance carrier I have identified in enrollment data for the purpose of filing claims related to my medical or vision care. I hereby authorize the attending medical provider to release all information necessary to secure the payment of benefits. I authorize the use of my signature below on all insurance submissions.

I authorize the release of pertinent medical and treatment documentation to other physicians involved in by care through referral or shared care.

I agree to assignment and release of insurance benefits to Arkansas Vision Development Center, for all insurance benefits, if any, otherwise payable to me for services rendered. I understand I am financially responsible for all charges incurred whether or not paid by insurance.

I understand that a photograph is included as a part of my electronic health record. I relieve Arkansas Vision Development Center, of any use of my Photograph for treatment, identification, or education purposes acknowledging that uses for any other purposes must be specifically obtained from me.

_____ _____

Patient Signature Date

As the Parent or legal guardian for a minor child, I am consenting for my child to receive treatment.

_____ _____

Name of Minor Patient Parent/Guardian Signature

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MEDICAL HISTORY

Name:_____Date of last eye exam:_____Todays date:_____

What medications do you currently take?_____

_____

List allergies to medications:_____

List any major illnesses or injuries (women please note if you have been pregnant in last 90 days).

_____

List any surgeries you have had:_____

Do you currently have any problems in the following areas? If yes please explain.

Glaucoma, Cataract, Retinal Disease, Etc.	*yes*	*no*
Double Vision	*yes*	*no*
Decreased or blurred vision spells	*yes*	*no*
Eye pain	*yes*	*no*
Floaters in your vision	*yes*	*no*
Flashing lights	*yes*	*no*
Eye injury	*yes*	*no*
Serious eye infection	*yes*	*no*
Dryness	*yes*	*no*
Sandy or gritty feeling	*yes*	*no*
Redness	*yes*	*no*
Burning	*yes*	*no*
Glare/light sensitivity	*yes*	*no*
Drooping eyelid	*yes*	*no*
General fatigue, fever, weight loss, etc.)	*yes*	*no*
Ears,Nose, Throat	*yes*	*no*
Cardiovascular (heart, vessels, etc.)	*yes*	*no*
Respiratory (asthma, emphysema, etc)	*yes*	*no*
Gastroinestinal (ulcers,crohns dz, etc)	*yes*	*no*
GU, kidney, bladder	*yes*	*no*
Muscles, bones, joints(arthritis,etc)	*yes*	*no*
Skin (acne, skin cancer, etc.)	*yes*	*no*
Neurological (multiple sclerosis, stroke, etc.)	*yes*	*no*
Psychiatric (anxiety, depression, insomnia)	*yes*	*no*
Endocrine (diabetes, thyroid, etc.)	*yes*	*no*
Blood/lymp(high cholesterol, anemia, etc.)	*yes*	*no*
Allergic/immunologic (hay fever, lupus, etc.)	*yes*	*no*

Explanation: _____

_____

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Family History: Mother-M Father-F Sibling-S Grandparent-GP

Cataracts	Yes	No	M	F	S	GP
Glaucoma	Yes	No	M	F	S	GP
Diabetes	Yes	No	M	F	S	GP
Macular Degen.	Yes	No	M	F	S	GP
Blindness	Yes	No	M	F	S	GP
Lazy Eye	Yes	No	M	F	S	GP
Other Eye Disorder	Yes	No	M	F	S	GP

Social History:

Current Occupation _____ Do you Drive?_____

Do you have visual difficulty when you drive?_____ Do you have problems with night vision?_____

Are you interested in contact lenses:____ Are you a previous contact lens wearer?_____

Do you work on a computer?____How many hours?____

What hobbies/pastimes do you presently enjoy?_____

Are you interested in refractive surgery?(Lasik)_____

Do you drink alcohol?____ How much?(circle one) occasional once a day more than once a day never

Do you smoke?____ How much?(circle one) occasional once a day more than once a day never

CONSENT TO RELEASE MEDICAL INFORMATION

I,_____, authorize the person(s) listed below to have knowledge of my medical information, including, but not limited to eye exams, office visits, treatment, and/or visual rehabilitation therapy, when I am not immediately available in person, or by a telephone call to _____.

Person(s) who may have access to my medical history (please print):

Name:_____Relationship to patient:_____Phone:_____

Name:_____Relationship to patient:_____Phone:_____

Name:_____Relationship to patient:_____Phone:_____

*Name:*_____

Contact number(s):_____

Address:_____City, State, Zip_____

Signature:_____Date:_____

***This consent is effective until withdrawn in writing.