WELCOME TO CALEDONIA VISION CENTER
WE ARE HAPPY YOU HAVE CHOSEN OUR OFFICE FOR YOUR PROFESSIONAL VISION CARE!

PATIENT INFORMATION

Patient Name:		Today's Date:	
Date of Birth:	Age:	Sex:	
Address:		Home Phone:	
Name of Account Responsible:		Work Phone:	Ext:

VISION REQUIREMENTS

Occupation: ____________________________ **Hobbies:** ____

Employer:____________________________ **Insurance Co:**___________________ **E-Mail** __________________________

Have you ever worn contact lenses? ☐ Yes ☐ No **Do you wear them now?** ☐ Hard ☐ Soft ☐ Disposable

Were you informed of our 2nd Pair Discount Program? ☐Yes ☐No

Are you interested in: ☐ Contact lenses ☐ New frame ☐ New lenses ☐ Sunglasses ☐ Computer Glasses

How did you hear about our office:____

FAMILY HEALTH HISTORY

Please check any of the following that apply to *YOUR FAMILY*:
☐ Diabetes ☐ Blindness ☐ Heart Disease ☐ Tuberculosis ☐ Eye Disease

PERSONAL EYE & MEDICAL HISTORY

Please check any of the following that apply to *YOU*, past and present:
☐ Allergies-list below ☐ Asthma ☐ Diabetes ☐ Dental Problems ☐ Drug Sensitivities
☐ Eye Disease ☐ Eye Surgery ☐ Fainting ☐ Glaucoma ☐ Hay Fever
☐ Headaches ☐ Head Injuries ☐ High Blood Pressure ☐ Hypoglycemia ☐ Sinus
☐ Skin Conditions ☐ Surgical Operations ☐ Thyroid ☐ Macular Degeneration
Allergies:____
If you experience regular headaches: How Often _____ Time of Day _____ For How Long ______ Treatment Used ______
Do you ever see things double? ☐ Yes ☐ No **Do you engage in activities with eye hazards?** ☐ Yes ☐ No

Primary Care Physician: ____ **PCP Phone number:** ______________________

Date of last general health examination: _________**Any abnormalities from exam?**_______________________________

Are you currently taking any medications? Please list: ____
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PAYMENT AUTHORIZATION

I authorize the doctors and staff of Caledonia Vision Center to perform services, and I authorize release of information relating to this claim. I authorize all third party payments directly to this provider for any benefits due (insurance related only). I understand that if insurance billing is approved, payment must be received from my insurance company within 30 days of the date of service or I am financially responsible and will pay my balance in full immediately. I understand Caledonia Vision Center will not become involved in divorce/custody agreements for any reason. The adult accompanying the minor will be responsible for any charges incurred. We will provide you with itemized statements to pass on to other responsible parties. We will not, however bill other parties directly. I understand that a written copy of this financial policy will be given to me upon request.

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Patient Name **Signature (Must be over 18)** **Date**

HIPAA PRIVACY POLICY

I acknowledge that I have received a copy of the Caledonia Vision Center *Notice of Privacy Policies*.

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Patient Name **Signature (Must be over 18)** **Date**