ClearVision Eye Centers

AffinityAnalytics Patient Tracking Form

Last Name, First Name	Preferred Name		Date Of Birth	Patient ID
Doctor	**Date**	**Appt. Time**	**Type of Exam**	**Category**
Last Encounter Date/Type:	**Reason for visit:**			
Medical Insurance:				
Vision Insurance:				

Your Doctor recommends annual digital photos of the back of the eye. These photos assist your Doctor in the identification of potentially blinding eye disorders and diseases such as: glaucoma, macular degeneration, diabetic eye diseases, etc. The photos are not covered by vision insurance, is that okay to do today?

☐ Yes ☐ No ☐ I would like more information

Patient Signature _____

Demographic Information:

Last Name: _____ First Name: _____ Preferred Name: _____

DOB: _____ Email: _____

Address: _____

☐ Home: _____ ☐ Work: _____ ☐ Cell: _____

SSN: _____ Occupation: _____ Place of Employment/School: _____

Primary Insured Information:

Last Name: _____ First Name: _____ DOB: _____ SSN: _____

Address: _____ Phone #: _____

It will be necessary to dilate your pupils in order to perform a complete and thorough eye examination. This allows the doctor to obtain a better view of the back of your eyes. The dilating drops typically last 3-4 hours. During this time you may find it difficult to focus at near and you may be sensitive to light. You will be provided with post-dilation sunglasses. We strongly recommend caution when driving or operating equipment or machinery after dilation. If you feel you would not be able to drive or return to work, we can reschedule the dilated portion of your exam.
UNDERSTANDING THE RISK AND BENEFITS OF FILATION: I **ACCEPT** **REFUSE** Dilation.
In the event that it becomes necessary for us to release your records to or request your records from another healthcare professional, your written permission is required. Please read and sign below.

PATIENT SIGNATURE (Patient or Guardian): _____

INSURANCE/FINANCIAL RESPONSIBILITY – PLEASE READ CAREFULLY

Our office attempts to obtain accurate insurance benefits for each patient. We must be provided with up-to-date information to do so. We do expect each patient to be familiar with his or her insurance benefits before coming in. Filing insurance is not a guarantee of payment. Any amount not paid by insurance will be your responsibility. In these situations, after the patient pays the co-payment, co-insurance, any deductible amount or any charge not covered by insurance, we will automatically file an insurance claim for reimbursement of the remainder of the balance directly to us. If your insurance program is not one we have contracted with, it is your responsibility to pay for the services and be reimbursed by your insurance. We will provide you with appropriate documentation to do so. Please be aware – in either situation, the ultimate responsibility for financial obligations lies with you. We appreciate your cooperation in this matter. If at any time, you have questions regarding insurance or billing, do not hesitate to contact our office. We will make all reasonable attempts to assist you. Thank you.

It is policy of this office to require:

1.) Payment in full or at least one-half before the order can be placed.
2.) The balance of the fee must be paid at the time the order is dispensed.
3.) A $25.00 charge will be assessed for returned checks.
4.) All orders are final when placed

WE THANK YOU FOR TAKING THE TIME TO COMPLETE THIS FORM AND FOR CHOOSING US TO PROVIDE YOUR VISION/EYE HEALTH CARE.

PATIENT SIGNATURE(Patient or Guardian): _____ DATE: _____

HEALTH INFORMATION

With your best vision correction on, have you suffered from any of the following:

☐ Near Vision Blur	☐ Red eyes	☐ Seeing spots/lines	☐ Headaches
☐ Distance Vision Blur	☐ Dry eyes	☐ Seeing flashes	☐ Double Vision
☐ Middle Distance Blur(dashboard/computer)	☐ Watery eyes	☐ Seeing haloes	☐ Indoor Glare
	☐ Pain in/around eyes	☐ Outdoor glare	

Do you have any special vision requirements (occupation/computer/hobbies/sports)? _____

How many hours per day do you spend on the computer? _____

Date of your last regular physical: _____ Family doctor: _____

Smoking status: __Current every day __Current some days __Former __Heavy Tobacco __Light Tobacco __Never

Do you currently drink alcohol: __Yes __No Could you currently be pregnant: __Yes __No

Do you currently wear glasses: __No __Yes (single vision/bifocal/progressive)

Do you currently wear contact lenses: __No __Yes (Brand:_____). How many hours per day? ___

Please list ALL the medications you are currently taking: _____

_____

Please list ANY medication allergies:_____

Please check all that apply

Condition	Yourself	Mother	Father	Sister	Brother	Son	Daughter
Cancer (Please list type)							
Neurological Problems							
Depression/Anxiety/ADD							
Heart Disease							
High Blood Pressure							
Lung Disease							
GI Disease							
Kidney/Bladder/Genital							
Infectious Disease							
Autoimmune Disease							
Arthritis							
Skin disease							
Diabetes							
Blood Disease							
Thyroid Disease							
High Cholesterol							
Cataracts							
Glaucoma							
Macular Degeneration							
Blindness							
Lazy Eye/Eye Turn							
Retinal Disorders							
Eye Injuries/Surgeries							