WELCOME TO PROFESSIONAL VISION CENTER

DR. TIMOTHY P. ANDERSON
PRACTICE OF OPTOMETRY
www.professionalvisioncenter.com
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PATIENT INFORMATION

Last Name_____ First Name_____ MI_____ Date of Birth_____

Address_____City_____ State_____ Zip_____

Phone (Home)_____ (Work)_____ (Cell) _____

E-mail _____ Social Security # _____

Please Circle: Married Divorced Separated Widow(er) Single Child (Grade) ____ Gender: M F

Ethnicity: Amer. Indian African Amer. Asian Hispanic/Latino Native Hawaiian/Pacific Islander White Other

Employer _____ Occupation/Job Title _____

How did you hear about our office? _____

INSURANCE / RESPONSIBLE PARTY INFORMATION

Primary Insurance Company _____ Secondary Insurance Company _____

Vision Insurance (if applicable) _____

Policy Holders Name _____ Relationship to patient _____

Address & Phone # (if different from above) _____

Date of Birth _____ Social Security # (for filing insurance) _____

Do you currently wear glasses? Yes No (If Yes: Prescription Non-prescription Full-time Part-time)

Do you want new glasses today? Yes No Only if prescription has changed

Do you wear contact lenses? Yes No (If Yes: Rigid Gas Permeable Soft Soft Toric Bifocal Disposable)

CL Wearing Schedule: Daily Wear (Remove at night) Extended Wear (do not remove overnight) Occ overnight wear

CL Solution(s) used to store/disinfect _____ Age of current CL _____

VISION AND MEDICAL HISTORY INFORMATION

Reason for visit today _____

When and where was your last eye exam (by an eye doctor) _____

Primary Care Physician _____ Phone # _____

Specialists _____ Phone # _____

Preferred Pharmacy _____ Address/Phone # _____

Height _____ft _____in Weight _____lb

Visual symptoms or conditions that apply to you:

____Blurred Vision ____Dry Eyes ____Floaters/Spots ____Droopy Eyelids

____Eye Strain ____Excessive tearing ____Flashing lights ____Cataract(s) / Surgery

____Light Sensitivity ____Burning/Stinging Eyes ____Lazy Eye/Eye Turn ____Glaucoma

____ Headaches ____ Itchy Eyes ____Color Deficiency ____Macular Degeneration

____Double Vision ____Red Eyes ____Loss of peripheral vision ____Retinal Detachment

____other (please explain) _____

Have you ever had any eye disease, eye injury, or eye surgery? No Yes _____

Medical Conditions that apply to you:

____Diabetes ____Asthma ____Thyroid Disease ____Anemia ____HIV/AIDS

____Hypertension ____Skin Conditions ____Kidney Disease ____Seizures ____ Hepatitis

____Elevated Cholesterol ____Migraines ____Arthritis/Joint Pain ____Cancer ____Pregnant

____Seasonal Allergies ____Heart Disease ____Lung Disease ____ Auto-Immune Disease

____Other (please explain)_____

Social History: Do you smoke tobacco? Yes No Socially Do you consume alcohol? Yes No Socially

Current Medications (including over-the-counter): _____

_____

Allergies to Medication (indicate side effect experienced): _____

List any eye or medical conditions that affect close blood relatives (and their relation to you): _____

_____

List any sports or hobbies you participate in:_____

Patient (or guardian/Parent) **Signature**_____ **Date**_____

Receipt of Notice of Privacy Practices & Consent Form

Professional Vision Center ● 3450 Asheville Hwy ● Hendersonville NC, 28791

1. Patient Name (print) _____ Date: _____

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services and to conduct health care operations involving our office. The ***Notice of Privacy Practices*** you have been given describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this form. As described in our ***Notice of Privacy Practices,*** the use and disclosure of your health information for treatment purposes not only includes services provided here, but also disclosures of your health information for purposes of payment includes (1) our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; (2) our submission of your health information to auditors hired by third-party payers and insurers; and (3) other aspects of payment described in our ***Notice of Privacy Practices.*** This notice will be updated whenever our privacy practices change. You can get an updated copy here at the office (or from our website). When you sign this consent, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services, and to perform healthcare operations. You also signify that you have received a copy of our ***Notice of Privacy Practices.*** You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment, or healthcare operations, but as described in our ***Notice of Privacy Practices***, we are not obliged to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our ***Notice of Privacy Practices*** describes how to ask for a restriction.

I have read and understood this document. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations. I acknowledge that I have received the *Notice of Privacy Practices* from Professional Vision Center.

_____

Patient Signature / Personal Representative of Patient Signature

If signing as a personal representative, describe the relationship and source of authority to sign this form:

_____

Print Name Relationship to Patient / Source of Authority

2. Communication Release Authorization

I give permission to Professional Vision Center to share my health information with the following people:

Name: _____ Relationship:_____ Contact Number _____

Name: _____ Relationship:_____ Contact Number _____

3. NEW Secure Patient Portal

You are invited to join our Secure Patient Portal. This is a 100% secure, encrypted, confidential, and easy-to-use website that will give you 24-hour access to your vision records. If you choose to take advantage of the portal, your name and email address will be treated with the same care and privacy given to your medical records. You may also use the portal to communicate and make requests directly to our office. Please take the time to check it out and provide us with feedback about the site and our office. We will not send out advertisements, promotions, or spam.

Patient E-Mail

_____