Welcome to Vision Today (**Print the answers to all questions. Your information will remain confidential per HIPAA policy**)

Name: _____ **Nickname:** _____
First Middle Last

If minor, PARENT/GUARDIAN name: _____

Street Address: _____ **Apt** _____ **City** _____ **State** _____ **Zip** _____

Cell Phone: _____ **Home Phone:** _____ **Email address:** _____

Date of Birth: _____ **Sex:** ❑ Male ❑ Female **SSN:** _____

Occupation (or Grade): _____ **Employer (or School):** _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Other

Who may we thank for telling you about our office? ❑ Facebook ❑ Google ❑ Yelp ❑ Insurance ❑ Previous Patient
❑ Walk By/Signage ❑ Referral from Friend or Family Member _____ ❑ Other _____

Race: ❑ African American ❑ Asian ❑ Caucasian ❑ Hispanic ❑ Native American ❑ Other

Preferred Language: ❑ English ❑ Other: _____

The name of your Medical Doctor is: _____ **Phone:** _____

AUTHORIZED USERS TO PATIENT'S RECORDS (EMERGENCY CONTACT):

Name: _____ **Phone:**_____ **Relationship to Patient:** _____

Name: _____ **Phone:**_____ **Relationship to Patient:** _____

Checking the Health of Your Eyes

The doctor strongly recommends all patients have the health of their eyes checked using our Retinal Screening Technology. This procedure involves capturing a digital picture and scan of the back of the eye, and detecting dysfunction in central and peripheral vision. This allows the doctor to evaluate for ocular diseases in more detail. We will also be able to track any changes that may occur through time. The screening is side effect free and may reduce exam time. It is NOT covered by any insurance and is an additional cost of $39.
*Disclaimer: If any abnormalities are detected, the doctor may dilate the pupils for further investigation.

YES / NO **I elect the Retinal Screening Technology to check the health of my eyes. ($39)**

The Florida Board of Optometry has established that a comprehensive eye examination for a new patient shall include a Dilated Fundus Exam. This procedure involves putting one or more drops in each eye that will dilate the pupils. The doctor will study the internal structures of your eye to ensure proper health. The drops administered will cause light sensitivity and some degree of blurred vision, especially near vision (effects can last up to 5 hours). Driving may be affected and should be done with extreme caution. Because your safety is of utmost importance to us, we prefer that you have someone with you to drive.

Personal Eye History

What is the reason for your visit today? Glasses / Contacts / Both / Other: _____

Do you have any of the following problems?

❑ Loss of Vision	❑ Blurred Vision	❑ Eye Pain or Soreness	❑ Infection of Eye or Lid
❑ Double Vision	❑ Dryness	❑ Halos	❑ Redness
❑ Sandy/Gritty Feeling	❑ Itching	❑ Mucous Discharge	❑ Floaters
❑ Excess Tearing/Watering		❑ Burning	❑ Flashes
❑ Sties or Chalazion	❑ Foreign Body Sensation	❑ Glare/Light Sensitivity	❑ Tired Eyes
			❑ Other _____

When was your last exam? (Approximately) _____ **Doctor's Name/Location:** _____

Do you have any ocular diseases or disorders? ❑ None ❑ Dry Eyes ❑ Cataract ❑ Glaucoma ❑ Macular Degeneration ❑ Retinal Disorder ❑ Amblyopia ❑ Crossed Eye ❑ Trauma ❑ Other _____

Have you had any eye surgeries? ❑ None ❑ Lasik ❑ RK ❑ Cataract ❑ Retina ❑ Eyelid ❑ Other _____

Do you wear GLASSES? ❑ No ❑ Yes **When do you wear your GLASSES?** ❑ Full time ❑ Part time

Do you wear CONTACTS? ❑ No ❑ Yes

If you know the Brand of your contacts, please indicate: _____

Personal Medical History (Many general medical conditions affect the eye and your vision)

❑ Please check this box if you DO NOT have any medical conditions.

Do you have problems with the following medical systems? (Please check all that apply in each box)

Constitutional ❑ None ❑ Weight loss ❑ Fatigue ❑ Trauma ❑ Fever ❑ Cancer ❑ Other _____	**Neurological** ❑ None ❑ Multiple sclerosis ❑ Epilepsy/Seizures ❑ Headaches ❑ Other _____	**Gastrointestinal** ❑ None ❑ Crohn's disease ❑ Colitis ❑ Ulcer ❑ Digestive concern ❑ Other _____
Allergic/Immunologic ❑ None ❑ Drug allergy ❑ Environmental Allergy ❑ Rheumatoid arthritis ❑ Lupus ❑ Other _____	**Endocrine** ❑ None ❑ Type 1 Diabetes ❑ Thyroid Dysfunction ❑ Type 2 Diabetes ❑ Hormonal Dysfunction ❑ Other _____	**Musculoskeletal** ❑ None ❑ Fibromyalgia ❑ Muscular dystrophy ❑ Osteoarthritis ❑Other_____
Cardiovascular ❑ None ❑ Heart disease ❑ Stroke ❑ Vascular disease ❑ High Blood Pressure/HTN ❑ High cholesterol	**Blood/Lymphatic** ❑ None ❑ Anemia ❑ Leukemia ❑ Other _____	**Integumentary/Skin** ❑ None ❑ Eczema ❑ Rosacea ❑ Psoriasis ❑ Other_____
Genitourinary ❑ None ❑ Urinary tract infections ❑ Kidney concerns ❑ Herpes ❑ Chlamydia ❑ HIV ❑ Other _____	**Psychiatric** ❑ None ❑ Depression ❑ Panic Disorder ❑ Schizophrenia ❑ Other _____	**Respiratory** ❑ None ❑ Asthma ❑ Bronchitis ❑ Emphysema ❑ Upper respiratory tract infection ❑ COPD ❑ Other _____
Ears, Nose & Throat ❑ None ❑ Sinus Problem ❑ Dry Throat/Mouth ❑ Other _____	List other medical conditions not mentioned here:	

Medication History

Do you take any prescription or non-prescription medicines regularly? ❑ no ❑ yes If yes, please list all medicines:

_____

_____

Do you have any medication allergies: ❑ None known ❑ Penicillin ❑ Sulfa drugs ❑ Other: _____

Family Medical History

Is there any family medical history of any of the following? (If yes, please list their relationship to you)

❑ None		❑ Corneal disease	_____
❑ Blindness	_____	❑ Lazy Eye	_____
❑ Cataracts	_____	❑ Diabetes	_____
❑ Glaucoma	_____	❑ Heart Disease	_____
❑ Macular	_____	❑ Hereditary Disease	_____
❑ Retinal	_____	❑ Other Eye Disorders	_____

Social History

Use tobacco? ❑ No ❑ Yes **Alcoholic Beverages?** ❑ No ❑ Yes **Illegal Drugs?** ❑ No ❑ Yes

Are you pregnant? ❑ No ❑ Yes **Breast feeding?** ❑ No ❑ Yes

Professional Service Policies

We strongly feel that all patients deserve from us the very best medical care that we can provide. Further, we feel that everyone benefits when definitive financial arrangements are agreed upon. Accordingly, we have prepared this material to acquaint you with our policy. **NO** prescriptions will be given until full patient balance is met. There are **NO REFUNDS** for professional service (eye exams, contact lens exam or medical visits) rendered unless a third party (such as an insurance company) is involved and they request it on your behalf. If you aren't satisfied with your purchase you can return for a full refund within 30 days of the original purchase. All balance dues must be paid in full within 90 days from original purchased date otherwise any partial payments will be forfeited. We will cover RX/ style change within 60days of the original purchase date, limit one per calendar year.

Please read and understand the following about **Glasses Prescription Rechecks/Follow-ups**:

If follow-up is within 60 days of finalized prescription there is no charge

1) After 60 days of finalized prescription there is a $35 fee (Patient must bring glasses to exam)
2) After 4 months patient must pay for a new full exam.

Our Contact lens follow up visits are intended to assess the quality of each patient's vision with the new contact lenses. We also determine if the patient is experiencing any adverse physiological changes secondary to wearing new contact lenses. These follow-up exams are usually scheduled within 1 to 2 weeks (depending on the type of contact lens) of dispensing the contacts. It is recommended to return with the contacts on unless they are causing a problem that makes wearing them too uncomfortable or not healthy for the eye.

Please read and understand the following about **Contact lens follow-up:**

1) Contact lens follow ups are ABSOLUTELY required unless a final prescription has been released according to our Contact lens release policy.
2) Contact lens fitting consists of 3 follow ups within a 60 day period of the original complete exam date at no charge.
3) Follow ups after 60 days of the complete exam will have a $35 fee per visit, up to 4 months from complete exam date.
4) After 4 months of complete exam, patient must pay for a new complete exam in order to finalize their contact lens prescription.
5) **Contact Lens Returns:**
    a. If you wish to exchange or return contact lenses, please return them within 30 days of your receipt of the product. ONLY unopened and unaltered contact lens vials or boxes may be returned or exchanged. Any boxes directly written on and/or marked by the customer will not be refunded or exchanged.

Insurance Information Release Policy

When making a third party claim, I authorize the release of my medical information to process my third party claim. I authorize Vision Today / James Powell, O.D. to file complaints on my behalf if my third party carrier does not properly handle my claim. I authorize the release of any information pertinent to my case to any third party, adjuster or attorney involved in resolving the financial status of my account. I authorize my third party plan to pay Vision Today / James Powell, O.D. directly. If my plan does not pay this claim, I agree to be responsible for the payment of these professional services.

Signing below acknowledges that you agree to our Insurance Information Release Policy and gives consent to the use and disclosure of Patient's health information for purposes of treatment, payment and healthcare options.

Signing below acknowledges that you were provided with a copy of your contact lens prescription at the completion of your contact lens fitting either in person or via our patient portal.

Signing below acknowledges that I have read and/or received a copy of Vision Today's Professional Service Policies and the Notice of Privacy Practices posted in the office. I give consent for the provider to provide, solicit, or arrange health care services or prescribe medicinal drugs for treatment of myself or the patient (if I am the parent / legal guardian of a minor).

_____	_____	_____
Patient Signature	Patient Name Printed	Date
_____	_____	_____
Legal Guardian Signature	Legal Guardian Name Printed	Date