



Welcome to Olathe Family Vision

What is the main reason for your visit today?		Today's Date:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Patient Last Name:	Patient First Name:	Patient SSN:	Date of Birth:	
Name of Parent/Guardian(If Applicable):				
Street Address:		City:	State:	Zip:
Email Address:		Employer/School Name:	Occupation or Grade:	
Home Phone:	Cell Phone:	Work Phone:	<input type="checkbox"/> English <input type="checkbox"/> Spanish	
Preferred Phone: <input type="checkbox"/> Home Phone <input type="checkbox"/> Cell Phone <input type="checkbox"/> Work Phone		Preferred Contact Method: <input type="checkbox"/> Email <input type="checkbox"/> Text Message <input type="checkbox"/> Mail <input type="checkbox"/> Phone		
Referred By:				

Doctor/Clinic of Last Eye Exam:		Date of Last Eye Exam:	
<input type="checkbox"/> Do you currently use glasses?		<input type="checkbox"/> Do you currently wear contact lenses?	
<input type="checkbox"/> Do you want info on LASIK/PRK?		<input type="checkbox"/> If not, would you like to?	
<input type="checkbox"/> Have you had LASIK/PRK? Year: Dr:		<input type="checkbox"/> Do you sleep in your contact lenses?	

Name of Family Physician:		Phone:	
Please check if you have a history of any of the following:			
<input type="checkbox"/> Eye injury or surgery	<input type="checkbox"/> Cataract	<input type="checkbox"/> Autoimmune disease	
<input type="checkbox"/> Retinal detachment/holes	<input type="checkbox"/> Cataract Surgery	<input type="checkbox"/> Thyroid Disease	
<input type="checkbox"/> Flashes	<input type="checkbox"/> Cancer	<input type="checkbox"/> Alcohol Use	
<input type="checkbox"/> Floaters	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Tobacco Use	
<input type="checkbox"/> Eye Turn/Amblyopia	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Learning/Reading Difficulties	
<input type="checkbox"/> Dry Eye	<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Other:	
<input type="checkbox"/> Macular degeneration	<input type="checkbox"/> Heart Disease		
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Anxiety/Depression		
List all medications you are currently taking, including eye drops and over the counter supplements:			

Family Medical & Eye History

Please check if any family members have a history of the following (if yes, please note relationship to you):			
<input type="checkbox"/> Cataract	<input type="checkbox"/> Retinal detachment	<input type="checkbox"/> Heart disease	
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High blood pressure	
<input type="checkbox"/> Macular Degeneration	<input type="checkbox"/> Cancer	<input type="checkbox"/> High cholesterol	
<input type="checkbox"/> Eye Turn/Amblyopia	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Other _____	
List any allergies to medications:			

Insurance Information

Vision Insurance _____ Subscriber's Name _____
Subscriber's Date of Birth _____ Employer _____
Subscriber's SSN _____ Insurance ID # _____

The eye health portion of your examination may be billable to your medical insurance.

Medical Insurance _____ Subscriber's Name _____
Subscriber's Date of Birth _____ Employer _____
Subscriber's SSN _____ Insurance ID # _____

Please Initial Each of the Following Sections:

_____ **Payment Policy:** By making an appointment at Olathe Family Vision, you are agreeing to abide by all billing policies of our practice. Payment is required at the time services are rendered or materials are ordered. Quotes of insurance coverage are based on information from the insurance company and are not guaranteed. Although we will gladly bill insurance for you, the patient remains responsible for their charges even after the insurance has been billed. If payment has not been received from insurance after 60 days, the patient will be expected to pay Olathe Family Vision directly.

_____ **Financial Responsibility:** I understand that I am personally responsible for payment of my account even if I have insurance. If it becomes necessary to use a collection agency for any amount owed on this or subsequent visits, the undersigned agrees to pay all costs and expenses including reasonable attorney's fees.

_____ **Cancellation Fee:** A cancellation charge of \$25 will be billed to you personally if you do not provide at least 24 hours' notice of a cancellation or change in your in your appointment date or time.

_____ **Photograph Release:** I hereby consent to photographs being taken for my medical record and to be shared on Olathe Family Vision social media. (Optional)

_____ **Release of Information:** I hereby authorize release of my information to my insurance company or to any health care professional or education professional when necessary for my health care billing. (This allows us to bill your insurance.)

_____ **Privacy Policy:** We respect our legal obligation to keep health information private. We are obligated by law to give you notice of our privacy practices. If you would like to receive a copy of our Notice of Privacy Practices, please request one from the receptionist today or at any time in the future. I understand that Mountain View Vision has a Notice of Privacy Practices available for my review if I wish. At the present time, I acknowledge that this notice has been offered and I accept the Notice of Privacy Practices.

_____ These policies will be enforced for both new patients and established patients. Our staff will be happy to answer any further question regarding these policies.

Signed (Patient/Patient Representative): _____ Date: _____

Description of Representative's Authority _____