ALLIEDVISION
SERVICES

Patient Information

Dr. ____ Mr. ____ Mrs. ____ Ms. ____ Miss ____ Marital Status: Married _____ Single _____ Divorced _____ Widowed _____

Name _____ Gender M / F Date of Birth_____

Address _____ City _____ State _____ Zip Code _____

Social Security # (Last four digits) _____ E-Mail _____

Telephone (H) _____ (W) _____ (C) _____

Employment Status: Full-time _____ Part-time _____ Unemployed _____ Student _____

Name of Employer: _____

Preferred Language (circle) English / Spanish / French / Japanese / Declined to Specify

Race (circle) American Indian or Alaskan Native / Asian / Black or African American / Hispanic
Native Hawaiian or Other Pacific Islander / White / Declined to Specify

Ethnicity (circle) Hispanic or Latino / Not Hispanic or Latino / Native Hawaiian or Other Pacific Islander / Declined to Specify

Communication Preference (circle) E-mail / Postal / Telephone

Responsible Party

Name of Person Responsible for the Account_____ Date of Birth _____

Address _____ Home Phone _____

Social Security # (Last four digits) _____ Relation to Patient _____ Currently a patient in our office? Yes ____ No ____

Employer _____ E-Mail _____

Primary Insurance Information

Insurance Company _____ ID# _____ Group # _____

Name of Insured: _____ Relation to Insured: _____

Employment Status: Full-time _____ Part-time _____ Unemployed _____ Student _____

Name of Employer: _____

Additional Insurance Information

Insurance Company _____ ID# _____ Group # _____

Name of Insured: _____ Relation to Insured: _____

Employment Status: Full-time _____ Part-time _____ Unemployed _____ Student _____

Name of Employer: _____

The preceding information is true to the best of my knowledge and I request any applicable payments of insurance be made on my behalf to Allied Vision Services for any services rendered. I authorize any holder of medical information about me to release to the insurance company and its agents any information needed to determine these benefits or benefits for related services. **I understand that I am responsible for any referrals needed for services rendered here (if in a managed care insurance program), and for any fees not covered by my insurance company owed to Allied Vision Services.**

Patient / Parent Signature _____ Date _____

Acknowledgement of Receipt

I acknowledge that I have received a copy of Allied Vision Services of Plainsboro's Notice of Privacy Practices.

Patient/Parent Signature _____ Date _____

MEDICAL HISTORY **NAME**_____ **DATE**_____

Vision plans cover "routine" eye exams. Some medical plans will only cover the visit if there is a medical reason for the visit, such as loss of vision, eye redness, eye discomfort, dry eyes, glaucoma, cataracts, floating spots, etc. If we are able to use your medical insurance to cover the visit, you will have to pay both the specialist copay as listed on your insurance card *and* the refraction fee (refraction is the part of the exam that determines your eyeglass prescription) We will help as much as possible to determine coverage, but ultimately, you are responsible for referrals and fees not covered or applied to your deductible.
For current contact lens wearers or those who want to be fit for contact lenses, there is an additional fee (other than the eye exam fee) for the evaluation and measurements necessary to determine the health, safety and proper lens selection for the eyes. This includes any wearing instructions, starter solutions/kits, and any follow-up visits to complete the fitting/evaluation, as determined by the doctor. These measurements and lens needs can change and will need to be re-evaluated over time.
Please initial that you understand the above statements: _____

Are you interested in purchasing new glasses today? Yes_____ No _____
Do you currently wear contact lenses? Yes_____ No _____ Are you interested in contact lenses? Yes____ No ____
Are you interested in Laser Vision Correction? Yes_____ No _____

REASON for VISIT: How can we help you today? Please tell us below the main eye/vision problem that you are having:
_____

Please circle your response (in **bold**):
Is the problem with the **RIGHT**, **LEFT**, **BOTH** eyes? Is it worse at **DISTANCE,** **CLOSE-UP**, or **BOTH**?
Is the problem **POOR VISION** or **DISCOMFORT**? Did it happen **SUDDENLY** or **GRADUALLY**?
Is the problem **MILD**, **MODERATE**, or **SEVERE**? Is the problem **CONSTANT** or **INTERMITTENT**?
Is the problem **RECENT** or **LONG TERM**?
Are there any associated symptoms? _____
Does anything alleviate the symptoms? _____

Review of Systems: Do you or any family member have or ever had the following? (Please check if "Yes")

	You	Family		You	Family
Allergies	____	____	**Headache**	____	____
Arthritis	____	____	**Heart Disease**	____	____
Asthma	____	____	**High Blood Pressure**	____	____
Autoimmune Disorder	____	____	**High Cholesterol**	____	____
Cancer	____	____	**Lung Problems**	____	____
Diabetes	____	____	**Neurological Problems**	____	____
Gastrointestinal Disease	____	____	**Genito/Urinary**	____	____
Psychiatric Disorders	____	____	**Skin Conditions**	____	____
Thyroid Disease	____	____	**Eye/Head Injury**	____	____
Glaucoma	____	____	**Eye Surgery**	____	____
Lazy Eye	____	____	**Other Eye Disease**	____	____

Females: Are you pregnant? Yes ___ No ____ How many months? ____ Are you nursing? Yes ___ No ___
Please list any medications you are taking now:_____
_____
_____
Are you a: Current Smoker_____ Former Smoker____ Quit, how many years ago? _____ Never Smoked_____
Alcohol use: Socially____ Daily use _____ Never_____
Any drug allergies? No _____ Yes _____ Please list: _____

If there are no changes to previous information already filled out above, please initial and date below:

Initial & date_____