VISION SOURCE®

103 N. River Street 605-745-3175

Name: _____ Date of Birth:_____

Mailing Address: _____ Patient SS# _____

(If under 18) Parent/Guardian: _____ Parent SS#_____

Email: _____ Phone: (Home)_____ (Cell)_____

How were you referred to us: Facebook/Twitter___ Google/Internet___ Newspaper___ Other _____

Friend/Family Member Name:_____

INSURANCE

Medical Insurance: _____ID# _____Group #_____

Secondary Insurance: _____ ID#_____Group# _____

Vision Benefit Plans: (Verify our participation in advance)

Primary Policy Holder: Self (circle) **OR** If not self, please complete below:

Name: _____ DOB: _____ SS# _____

NOTICE OF PRIVACY POLICY

_____I am aware that a copy of the Notice of Privacy Policy is available in the reception area.

SIGNATURE OF INSURANCE ASSIGNMENT

Verify your insurance benefits and pre-authorization requirements. Be mindful of your deductable, co-pay and out of pocket co-insurance amounts. As a courtesy we will submit a claim to your Health Care Plan, if applicable. Co-pays are due on the date of service. You are responsible for any remaining balances. Balances over 90 days will be sent to collections.
I authorize payment of medical/vision benefits to Vision Source for services or ophthalmic products. I authorize release of any medical or other information necessary to process claims.

_____ _____

Patient/Guardian Signature Date

VISION SOURCE

Dr. Dallas Wilkinson

Welcome to our office

Find us on **Facebook** and visit us at **www. VisionSourceHS.com**

Race

☐ White ☐ American Indian ☐ Asian ☐ Other Race ☐ Black/African American

Ethnicity

☐ Hispanic or Latino ☐ Not Hispanic or Latino

Pharmacy _____

Primary Doctor _____

Specialty Doctor _____

Social History

Drink

☐ Yes ☐ No

Amount / How long _____

Tobacco use

☐ Yes ☐ No

Amount / How long _____

Former Smoker

☐ Yes ☐ No

Constitutional

☐ Developmental ☐ Disabilities ☐ Cancer ☐ Fatigue Syndrome

Muscular Skeletal

- ☐ Osteoarthritis
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Ankylosing Spondylitis
- ☐ Osteoporosis
- ☐ Gout

Gastrointestinal

- ☐ Chrohn's Disease
- ☐ Colitis
- ☐ Ulcer
- ☐ Acid Reflux
- ☐ Celiac Disease

Respiratory

- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Chronic Obstruction
- ☐ Sleep Apnea

Neurological

- ☐ Multiple Sclerosis
- ☐ Epilepsy
- ☐ Cerebral Palsy
- ☐ Tumor
- ☐ Stroke
- ☐ Migraine

Genitourinary

- ☐ Kidney Disease
- ☐ Prostate
- ☐ STD
- ☐ Pregnant
- ☐ Nursing

Allergy/ Immune

- ☐ Drug allergies
- ☐ Environmental Allergies
- ☐ Rheumatoid Arthritis
- ☐ Lupus
- ☐ Sjorgen's syndrome

Ear, Nose, Throat

- ☐ Hearing Loss
- ☐ Sinusitis
- ☐ Dry Mouth
- ☐ Laryngitis

Hematologic/ Lymphatic

- ☐ Anemia
- ☐ Large volume blood loss
- ☐ Ulcer
- ☐ Cholesterol

Endocrine

- ☐ Type 2 Diabetes
- ☐ Type 1 Diabetes
- ☐ Thyroid
- ☐ Hormonal Dysfunction

Psychiatric	Integumentary	Cardiovascular
☐ Depression	☐ Eczema	☐ Hypertension
☐ Attention Deficit	☐ Rosacea	☐ Stroke
☐ Anxiety	☐ Psoriasis	☐ Heart Disease
☐ Bipolar	☐ Cold Sores	☐ Vascular Disease
	☐ Shingles	☐ Congestive Heart Failure

Eyes		
☐ Vision Loss	☐ Itching	☐ Floating Spots
☐ Blurry Vision	☐ Burning	☐ Tired Eyes
☐ Distorted Vision	☐ Excess Watering	☐ Cataracts
☐ Double Vision	☐ Light Sensitivity	☐ Diabetic Retinopathy
☐ Dryness	☐ Eye Pain/Soreness	☐ Glaucoma
☐ Redness	☐ Chronic Infection	☐ Macular Degeneration
☐ Mucous Discharge	☐ Sties	☐ Retinal Detachment
☐ Gritty Feeling	☐ Flashes	

Medical History

Allergies	Medications
Surgeries	Ocular History

Family Medical History: Note relation to yourself in the box below

Please list (F) father, (M) mother, (S) sister, (B) brother, (So) son, (D) daughter

☐ Cancer _____	☐ Cataracts
☐ Insulin diabetes _____	☐ Macular Degeneration _____
☐ Non insulin diabetes _____	☐ Glaucoma
☐ Hypertension _____	
☐ Hyperthyroidism _____	
☐ Hypothyroidism _____	

Signature_____Date_____