200 S. Chicago Street 605-745-3175 info@visionsourcehs.com

Name: _____ Date of Birth:_____

Mailing Address: _____ Patient SS# _____

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

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

Vision Benefit Plans: (Verify with your carrier if we are In-Network)

MEDICAL INSURANCE

Primary Insurance: _____ID# _____Group #_____

Secondary Insurance: _____ ID#_____ Group# _____

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 deductible, 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®

Welcome to our office

Primary Doctor_____

Specialty Doctor_____

Pharmacy_____

Social History (circle Yes or No)

Drink: Yes / No

Amount (If yes): _____

Tobacco Use: Yes / No

Tobacco Type (Circle all that apply if 'Yes'):

Cigarettes / Cigars / Pipes / Smokeless Tobacco

Amount: _____

(Circle one) Every Day Use / Some Day Use

Former Smoker: Yes / No

Race

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

Ethnicity

◯ Hispanic or Latino ◯ Not Hispanic or Latino

Please review list below and check any conditions you currently have or are currently being treated for (check all that apply):

Constitutional
- ☐ Developmental Disabilities
- ☐ Cancer
- ☐ Fatigue Syndrome
- ☐ Other: _____

Ear, Nose, Throat
- ☐ Hearing Loss
- ☐ Sinusitis
- ☐ Dry Mouth
- ☐ Laryngitis
- ☐ Other: _____

Neurological
- ☐ Multiple Sclerosis
- ☐ Epilepsy
- ☐ Tumor
- ☐ Stroke
- ☐ Migraine
- ☐ Other: _____

Psychiatric
- ☐ Depression
- ☐ Attention Deficit
- ☐ Anxiety
- ☐ Bipolar
- ☐ Other: _____

Cardiovascular
- ☐ Hypertension
- ☐ Stroke
- ☐ Heart Disease
- ☐ Vascular Disease
- ☐ Congestive Heart Failure
- ☐ Other: _____

Respiratory
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Chronic Obstruction
- ☐ Sleep Apnea
- ☐ Other: _____

Gastrointestinal
- ☐ Crohn's Disease
- ☐ Colitis
- ☐ Ulcer
- ☐ Acid Reflux
- ☐ Celiac Disease
- ☐ Other: _____

Genitourinary
- ☐ Kidney Disease
- ☐ Prostate
- ☐ STD
- ☐ Pregnant
- ☐ Nursing
- ☐ Other: _____

Muscular Skeletal
- ☐ Osteoarthritis
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Osteoporosis
- ☐ Gout
- ☐ Other: _____

Integumentary
- ☐ Eczema
- ☐ Rosacea
- ☐ Psoriasis
- ☐ Cold Sores
- ☐ Shingles
- ☐ Other: _____

Endocrine
- ☐ Type 2 Diabetes
- ☐ Type 1 Diabetes
- ☐ Thyroid
- ☐ Hormonal Dysfunction
- ☐ Other: _____

Hematologic/ Lymphatic
- ☐ Anemia
- ☐ Large volume blood loss
- ☐ Ulcer
- ☐ Cholesterol
- ☐ Other: _____

Allergy/ Immune
- ☐ Drug allergies
- ☐ Environmental Allergies
- ☐ Rheumatoid Arthritis
- ☐ Sjorgen's syndrome
- ☐ Other: _____

PLEASE CONTINUE TO BACK SIDE

Eyes		
☐ Vision Loss ☐ Blurry Vision ☐ Distorted Vision ☐ Double Vision ☐ Dryness ☐ Tired Eyes	☐ Gritty Feeling ☐ Mucous Discharge ☐ Redness ☐ Itching ☐ Burning ☐ Excess Watering	☐ Light Sensitivity ☐ Eye Pain/Soreness ☐ Styes ☐ Flashes ☐ Floating Spots ☐ Other: _____

Medications:

Ocular History (Check All That Apply):

- ☐ Cataracts
- ☐ Diabetic Retinopathy
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Retinal Detachment
- ☐ Other: _____

Ocular Surgeries:

- ☐ Cataract Surgery
- ☐ Lasik / PRK
- ☐ Other: _____

Medication / Environmental Allergies:

Latex Sensitivity (Circle one): Yes / No

Family Ocular History: Note relation to yourself

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

- ☐ Cataracts _____
- ☐ Macular Degeneration _____
- ☐ Glaucoma _____

Signature_____**Date**_____

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