VISION SOURCE

200 S. Chicago 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

Welcome to our office

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

Race

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

Ethnicity

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Primary Doctor _____

Specialty Doctor_____

Pharmacy _____

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

PLEASE CONTINUE TO BACKSIDE

Psychiatric

- ☐ Depression
- ☐ Attention Deficit
- ☐ Anxiety
- ☐ Bipolar

Integumentary

- ☐ Eczema
- ☐ Rosacea
- ☐ Psoriasis
- ☐ Cold Sores
- ☐ Shingles

Cardiovascular

- ☐ Hypertension
- ☐ Stroke
- ☐ Heart Disease
- ☐ Vascular Disease
- ☐ Congestive Heart Failure

Eyes

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

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_____