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)_______________

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 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**

Welcome to our office

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

Primary Doctor______________________________ **Specialty Doctor**______________________________ **Pharmacy**______________________________	**Social History** (circle Yes or No) Drink: Yes / No Amount/How long ________________ Tobacco Use: Yes / No Amount/How long ________________ Former Smoker: Yes / No Amount/How long ________________

Check all that apply:

Race ☐ American Indian ☐ Asian ☐ Black/African American ☐ Other Race ☐ White	**Ethnicity** ☐ Hispanic or Latino ☐ Not Hispanic or Latino	**Constitutional** ☐ Developmental Disabilities ☐ Cancer ☐ Fatigue Syndrome
Ear, Nose, Throat ☐ Hearing Loss ☐ Sinusitis ☐ Dry Mouth ☐ Laryngitis	**Neurological** ☐ Multiple Sclerosis ☐ Epilepsy ☐ Cerebral Palsy ☐ Tumor ☐ Stroke ☐ Migraine	**Psychiatric** ☐ Depression ☐ Attention Deficit ☐ Anxiety ☐ Bipolar
Cardiovascular ☐ Hypertension ☐ Stroke ☐ Heart Disease ☐ Vascular Disease ☐ Congestive Heart Failure	**Respiratory** ☐ Asthma ☐ Bronchitis ☐ Emphysema ☐ Chronic Obstruction ☐ Sleep Apnea	**Gastrointestinal** ☐ Crohn's Disease ☐ Colitis ☐ Ulcer ☐ Acid Reflux ☐ Celiac Disease
Genitourinary ☐ Kidney Disease ☐ Prostate ☐ STD ☐ Pregnant ☐ Nursing	**Muscular Skeletal** ☐ Osteoarthritis ☐ Arthritis ☐ Fibromyalgia ☐ Osteoporosis ☐ Gout	**Integumentary** ☐ Eczema ☐ Rosacea ☐ Psoriasis ☐ Cold Sores ☐ Shingles
Endocrine ☐ Type 2 Diabetes ☐ Type 1 Diabetes ☐ Thyroid ☐ Hormonal Dysfunction	**Hematologic/ Lymphatic** ☐ Anemia ☐ Large volume blood loss ☐ Ulcer ☐ Cholesterol	**Allergy/ Immune** ☐ Drug allergies ☐ Environmental Allergies ☐ Rheumatoid Arthritis ☐ Lupus ☐ Sjorgen's syndrome

PLEASE CONTINUE TO BACK SIDE

Vision Source

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 Ocular History: Note relation to yourself in the box below

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

- ☐ Cataracts ____________
- ☐ Macular Degeneration ____________
- ☐ Glaucoma ____________

Signature____ **Date**____________