



# WELCOME TO OUR OFFICE

Name \_\_\_\_\_ Social Security # \_\_\_\_/\_\_\_\_/\_\_\_\_

Street \_\_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_  M  F

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Email \_\_\_\_\_

Home Phone \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_ Last Exam Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Occupation or Grade \_\_\_\_\_ Employer \_\_\_\_\_

Spouse or Parent's Name \_\_\_\_\_ Spouse or Parent's Work Phone \_\_\_\_\_

In Case of Emergency Notify \_\_\_\_\_ Phone \_\_\_\_\_

Whom may we thank for referring you to our office \_\_\_\_\_

Or were you introduced by  Location  Ins. Co  Phone Book  Media \_\_\_\_\_  Other \_\_\_\_\_

What is the major purpose of this visit?  Annual Check Up  Corneal Refractive Therapy (CRT)  
 New Eyewear  New Contact Lenses  Laser Surgery (Lasik) Consultation  
 Other \_\_\_\_\_

Have you ever worn or do you currently wear contact lenses?  Yes  No

Any problems with your present contact lenses or glasses?  Yes  No \_\_\_\_\_

Are you interested in any of the following?  Corneal Refractive Therapy (CRT)  Sunglasses  
 Bifocal Contact Lenses  Continuous Contact Lenses  Refractive Surgery  
 Laser Surgery (Lasik) Consultation

Special Interests (hobbies, sports, occupational needs) \_\_\_\_\_

**INSURANCE INFORMATION — PLEASE PRESENT CARD AT TIME OF SERVICE**

Medical Insurance \_\_\_\_\_ Vision Insurance \_\_\_\_\_ Insured's Name \_\_\_\_\_

Insured's Social Security Number \_\_\_\_/\_\_\_\_/\_\_\_\_ Relationship to Patient \_\_\_\_\_

**Acknowledgement of Receipt of Privacy Notice**

Patient understands and agrees to allow Advanced Vision to use her/his Patient Health Information for the purpose of treatment, payment, health care operations and coordination of care. Patient can be assured that Advanced Vision does not sell Personal Health Information of any kind to a third party for such party's own use. Advanced Vision wants you to know how your Patient Health Information is going to be used, and rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of our Patient Health Information, before signing this consent we encourage you to read "How We Protect Your Privacy," which is available to you at the front desk. If there is anyone you do not want to receive your medical records, please inform our office.

**PAYMENT IS DUE AT TIME OF SERVICE.**

**METHOD OF PAYMENT  CASH  CHECK  CREDIT CARD**

I request that payment of insurance benefits be made on my behalf to Advanced Vision, LLC for any services furnished my by Advanced Vision, LLC. I authorize any holder of medical information about me to release to my insurance carrier and its agents any information needed to determine these benefits or the benefits payable for related services.

I authorize and agree to pay for all services rendered to me not covered by Medicare or other insurance.

Signature \_\_\_\_\_ Date \_\_\_\_\_

*Please complete section on back.*

■ **Are you currently experiencing:**

- |   |   |   |  |
|---|---|---|--|
| Yes No  | Yes No  | Yes No  | Yes No   |
| <input type="checkbox"/> <input type="checkbox"/> Burning | <input type="checkbox"/> <input type="checkbox"/> Headaches           | <input type="checkbox"/> <input type="checkbox"/> Head Trauma       | <input type="checkbox"/> <input type="checkbox"/> Floaters |
| <input type="checkbox"/> <input type="checkbox"/> Tearing | <input type="checkbox"/> <input type="checkbox"/> Blurred Far Vision  | <input type="checkbox"/> <input type="checkbox"/> Double Vision     | Other: _____   |
| <input type="checkbox"/> <input type="checkbox"/> Redness | <input type="checkbox"/> <input type="checkbox"/> Blurred Near Vision | <input type="checkbox"/> <input type="checkbox"/> Light Sensitivity | _____  |
| <input type="checkbox"/> <input type="checkbox"/> Itching | <input type="checkbox"/> <input type="checkbox"/> Pain in/Around Eye  | <input type="checkbox"/> <input type="checkbox"/> Flashes of Light  | _____  |

■ **Eye Diseases: Do you now, or have you ever had, any of the following eye diseases?**

- |   |  |   |
|---|--|---|
| Yes No  | Yes No   | Yes No  |
| <input type="checkbox"/> <input type="checkbox"/> Cataract        | <input type="checkbox"/> <input type="checkbox"/> Diabetic Retinopathy | <input type="checkbox"/> <input type="checkbox"/> Lazy Eye    |
| <input type="checkbox"/> <input type="checkbox"/> Glaucoma        | <input type="checkbox"/> <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> <input type="checkbox"/> Injury      |
| <input type="checkbox"/> <input type="checkbox"/> Detached Retina | <input type="checkbox"/> <input type="checkbox"/> Crossed Eyes         | <input type="checkbox"/> <input type="checkbox"/> Keratoconus |

■ **Family History: Have your parents, grandparents or siblings had any of the following diseases?**

- |   |  |   |  |
|---|--|---|--|
| Yes No  | Yes No   | Yes No  | Yes No   |
| <input type="checkbox"/> <input type="checkbox"/> Blindness | <input type="checkbox"/> <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> <input type="checkbox"/> Heart Disease | <input type="checkbox"/> <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> <input type="checkbox"/> Cataract  | <input type="checkbox"/> <input type="checkbox"/> Retinal Detachment   | <input type="checkbox"/> <input type="checkbox"/> Stroke        | <input type="checkbox"/> <input type="checkbox"/> Cancer   |
| <input type="checkbox"/> <input type="checkbox"/> Glaucoma  | <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure  | <input type="checkbox"/> <input type="checkbox"/> Thyroid       | <input type="checkbox"/> <input type="checkbox"/> Other    |

■ **Past Illnesses/Injuries/Surgeries: Please list all past major illnesses, injuries or surgeries you have had.**

\_\_\_\_\_

\_\_\_\_\_

■ **Current Conditions: Do you currently have any of the following conditions?**

- |  |   |  |
|--|---|--|
| Yes No   | Yes No  | Yes No   |
| <input type="checkbox"/> <input type="checkbox"/> Fever/Weight Loss          | <input type="checkbox"/> <input type="checkbox"/> Diabetes/Thyroid Problems         | <input type="checkbox"/> <input type="checkbox"/> Psychiatric Problems                   |
| <input type="checkbox"/> <input type="checkbox"/> Ears/Mouth/Throat Problems | <input type="checkbox"/> <input type="checkbox"/> Stomach/Intestinal Problems       | <input type="checkbox"/> <input type="checkbox"/> Headache                               |
| <input type="checkbox"/> <input type="checkbox"/> Nose/Sinus Problems        | <input type="checkbox"/> <input type="checkbox"/> Kidney/Urinary/Genital Disease    | <input type="checkbox"/> <input type="checkbox"/> HIV/AIDS                               |
| <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure        | <input type="checkbox"/> <input type="checkbox"/> Pregnant                          | <input type="checkbox"/> <input type="checkbox"/> Seasonal Allergies                     |
| <input type="checkbox"/> <input type="checkbox"/> Irregular Heart Beat       | <input type="checkbox"/> <input type="checkbox"/> Blood Disorder/Prolonged Bleeding |  |
| <input type="checkbox"/> <input type="checkbox"/> Other Heart Disease        | <input type="checkbox"/> <input type="checkbox"/> Stroke/Neurological Disease       | <b>Do you use:</b>   |
| <input type="checkbox"/> <input type="checkbox"/> Asthma or Emphysema        | <input type="checkbox"/> <input type="checkbox"/> Joint/Muscle Pain                 | <input type="checkbox"/> <input type="checkbox"/> Alcohol                                |
| <input type="checkbox"/> <input type="checkbox"/> Other Lung Disease         | <input type="checkbox"/> <input type="checkbox"/> Skin Disease                      | <input type="checkbox"/> <input type="checkbox"/> Tobacco <input type="checkbox"/> Never |

■ **Do you have any drug sensitivities/allergies?**       Yes    No

■ **Are you currently under a physician's care?**       Yes    No   Family Physician \_\_\_\_\_

■ **Current Medications: Prescription or Over the Counter:**

Medications: \_\_\_\_\_ For: \_\_\_\_\_

Medications: \_\_\_\_\_ For: \_\_\_\_\_

Medications: \_\_\_\_\_ For: \_\_\_\_\_

Others: \_\_\_\_\_

**FOR OFFICE USE ONLY**

**Doctor**

Signature \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

A. Sahba Jalali, O.D.

**Patient**

Signature \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_