REGISTRATION FORM

Advanced Vision of Ironton LLC, Ironton, OH

Today's Date: _____/_____/_____

Name:_____ **Date of Birth:**_____/_____/_____

☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms. ☐ Dr. **Social Security # (for billing purposes)** _____

Address: _____

City: _____ State:_____ ZIP: _____

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

E-Mail: _____ Work Phone: ( ) _____

Occupation: _____ Employer Name: _____

Primary Physician: _____ Address_____

Hobbies: _____

IF UNDER 18 – Parents Name: _____ Date of Birth: _____

Vision Insurance: _____
☐ insured under self
☐ insured under spouse/parent →Name: _____

DOB: _____ SSN:_____

Primary Medical Ins: _____ Secondary Medical (if applicable):_____

☐ insured under self
☐ insured under spouse/parent →Name: _____

DOB: _____ SSN:_____

PLEASE NOTE: We are providers for most insurance programs (VSP, BC/BS, Medicare…). Please consult your insurance manual for details regarding deductibles and maximum payments. Some procedures and materials that are medically necessary may not be covered by insurance; these services are the responsibility of the patients. PATIENT IS RESPONSIBLE FOR ALL CHARGES NOT PAID BY INSURANCE, INCLUDING MEDICARE CO-INSURANCE AND DEDUCTIBLES. I authorize payments of benefits for services per assignment and assume responsibility for all charges. I authorize the release of information necessary to my claims. I UNDERSTAND THAT PROFESSIONAL FEES ARE NON-REFUNDABLE. I hereby consent and allow my examination findings to be shared with other professionals responsible for my care. All returned checks will incur a NSF fee of $30. We reserve the right to no longer be your eye care provider if you do no abide by our policies. **I received/read a copy of the HIPPA notice and the policies outlined. All copays and deductibles, glasses/contact lens orders are due at time of visit.**

Please sign here **X** _____

Relationship (if under 18yrs) _____

MEDICAL HISTORY

Today's Date: _____/_____/_____ **Advanced Vision of Ironton LLC Ironton, OH**

Name: _____ **Date of Birth:** _____/_____/_____

FAMILY HISTORY:

Anyone in your family ever had/has:

Diabetes	☐ YES ☐ NO	**Glaucoma**	☐ YES ☐ NO
High Blood Pressure	☐ YES ☐ NO	**Turned eyes**	☐ YES ☐ NO
Macular Degeneration	☐ YES ☐ NO	**Other:** _____	

SELF HISTORY:

Have you ever had or have:

Flashes of lights in eyes	☐ YES ☐ NO	**Glaucoma**	☐ YES ☐ NO
Cataract	☐ YES ☐ NO	**Turned eyes**	☐ YES ☐ NO
Macular degeneration	☐ YES ☐ NO	**Eye surgery**	☐ YES ☐ NO
Retinal detachment	☐ YES ☐ NO		
Recent floaters	☐ YES ☐ NO	**Other:** _____	

Your Primary Care Physician: _____

List **Medications** you are taking (if any): _____

_____

_____

_____

_____

List any Medication you are **ALLERGIC** to (if any): _____

_____

Smoke/other tobacco ☐ **YES** ☐ **NO** how many/day: _____ **Drink Alcohol** ☐ **YES** ☐ **NO** → ☐ socially ☐ above average

Marijuana/recreational drugs? ☐ **YES** ☐ **NO** If yes, what type: _____

LAST eye exam (year): _____ Do you wear Contacts ☐ **YES** ☐ **NO** Interested? ☐ **YES** ☐ **NO** (fitting fees apply)

Please **CHECK** if **YOU** have/had any of the following problems (if none do not check):

-SELF- GENERAL HEALTH

Cardiovascular
- ☐ High Cholesterol
- ☐ Vascular disease
- ☐ Stroke
- ☐ Heart Disease
- ☐ High blood pressure

Constitutional
- ☐ Frequent Headaches
- ☐ Cancer
- ☐ Fatigue/fever Syndrome
- ☐ Developmental Disability
- ☐ Pregnant/may be pregnant

Skin disorders
- ☐ Eczema
- ☐ Rosacea
- ☐ Psoriasis

Other: _____

Musculoskeletal
- ☐ Ankylosing Spondylitis
- ☐ Osteoarthritis
- ☐ Muscular Dystrophy
- ☐ Fibromyalgia

Hematological/Lymph
- ☐ Blood loss
- ☐ Leukemia
- ☐ Anemia

Immunologic/Allergic
- ☐ HIV
- ☐ Rheumatoid Arthritis
- ☐ Lupus
- ☐ Allergies

Respiratory
- ☐ COPD
- ☐ Bronchitis
- ☐ Asthma

Gastrointestinal
- ☐ Colitis/Chron's
- ☐ Ulcer
- ☐ Digestive

Genitourinary
- ☐ Prostate disease/cancer
- ☐ Kidney disease
- ☐ STD – HIV/herpes etc.

Neurological
- ☐ Multiple Sclerosis
- ☐ Epilepsy
- ☐ Tumor
- ☐ Cerebral Palsy

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ Panic Disorder
- ☐ Schizophrenia

Endocrine
- ☐ Diabetes
- ☐ Thyroid disease

Ear/Nose/Throat
- ☐ Hearing loss
- ☐ Sinusitis
- ☐ Dry mouth