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: (   )____________________________

Work Phone: (   ) _________________________

Employer Name/Occupation: __________________________________

Family Physician________________________________ Address____________________________________

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:

Macular Degeneration	☐ YES ☐ NO	**Glaucoma**	☐ YES ☐ NO
Blindness	☐ YES ☐ NO	**Lazy Eye**	☐ YES ☐ NO
High Blood Pressure	☐ YES ☐ NO	**Diabetes**	☐ YES ☐ NO
Cataract	☐ YES ☐ NO	**Other:** __________________	

SELF:

List Medications you are taking (if any): ____

____

____

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

Smoke or other tobacco ☐ **YES** ☐ **NO** how many/day: _________

Drink Alcohol ☐ **YES** ☐ **NO** how often: _____________ **Marijuana/recreational drugs**? ☐ **YES** ☐ **NO**

Your LAST eye exam (year): ________

Are you wearing Contact Lenses ☐ **YES** ☐ **NO** Interested in Contacts? ☐ **YES** ☐ **NO** (CL's fee range from $49-109)

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

GENERAL HEALTH -SELF-

Cardiovascular	Endocrine	Hematological/Lymph	Genitourinary
☐ Hypertension	☐ Diabetes	☐ Anemia	☐ Kidney disease
☐ Stroke	☐ Thyroid problems	☐ High Cholesterol	☐ STD – AIDS/herpes
☐ Heart Disease		☐ Blood loss	☐ Prostate disease/cancer
Constitutional	**Allergic/Immunologic**	**Respiratory**	**Musculoskeletal**
☐ Headaches	☐ Allergies	☐ Asthma	☐ Osteoarthritis
☐ Cancer	☐ Rheumatoid Arthritis	☐ Bronchitis	☐ Muscular Dystrophy
☐ Fatigue Syndrome	☐ Lupus	☐ COPD	☐ Ankylosing Spondylitis
☐ Developmental Disability			
Gastrointestinal	**Ear/Nose/Throat**	**Neurological**	**Skin disorders**
☐ Colitis/Chron's	☐ Hearing loss	☐ Multiple Sclerosis	☐ Eczema
☐ Ulcer	☐ Sinusitis	☐ Epilepsy	☐ Psoriasis
	☐ Dry mouth	☐ Tumor	☐ Rosacea
Psychiatric		☐ Cerebral Palsy	
☐ Depression	Other: ______________________________________		

EYE CONDITIONS -SELF-

☐ Glaucoma	☐ Macular Degeneration	☐ Flashes of light in eye(s)	☐ Light Sensitivity
☐ Floaters in eye(s)	☐ Eye Trauma	☐ Eye Surgery	☐ Retinal Detachment

☐ Other: ____