New Patient Registration

Today's Date: _____

Doctor: _____

Patient Contact Information

FIRST NAME _____ **SEX** ( ) MALE ( ) FEMALE

LAST NAME _____ **SS #** _____

MIDDLE INITIAL _____ Title _____ **MARITAL STATUS** [ ] Single [ ] Married [ ] Divorced

PREFERRED NAME _____ [ ] Widowed

ADDRESS _____ **EMP. STATUS** [ ] Employed [ ] Not Employed [ ] Retired

ZIP _____ [ ] Student [ ] Self-Employed. [ ] Military

HOME PHONE _____ **OCCUPATION** _____

CELL PHONE* _____ **RACE** [ ] Am. Indian [ ] Asian [ ] Native [ ] White

EMAIL* _____ [ ] Black/African Am. [ ] Native Hawaiian/Other Pacific Islander

D.O.B. _____ **ETHNICITY** [ ] Hispanic or Latino

The Vision Hub is NOW digital. All notifications will be delivered to you via text/email. [ ] Not Hispanic or Latino

Parent - Guardian Contact Information - Patients UNDER 18

LAST NAME _____ **D.O.B** _____

FIRST NAME _____ **SS #** _____

HOME PHONE _____ **ADDRESS** _____

CELL PHONE _____ **CITY/STATE** _____ **ZIP** _____

EMAIL _____ **EMP. STATUS** _____

Insurance Information

Please drop your Vision and Medical Insurance cards off at the front desk if you haven't already. Thank you!

PRIMARY INSURED _____ **D.O.B.** _____

How did you hear about us….

DOCTOR REFERRAL	( ) YES ( ) NO	**INSURANCE COMPANY**	( ) YES ( ) NO
PATIENT REFERRAL	( ) YES ( ) NO	**FRIENDS/FAMILY**	( ) YES ( ) NO
EMPLOYEE REFERRAL	( ) YES ( ) NO	**WALK-IN**	( ) YES ( ) NO
FACEBOOK	( ) YES ( ) NO	**ADVERTISING**	( ) YES ( ) NO
LOCATION	( ) YES ( ) NO	**RECALL CARD/EMAIL**	( ) YES ( ) NO
GOOGLE	( ) YES ( ) NO		
DRIVE BY	( ) YES ( ) NO	**OTHER**	_____

Lifestyle Information

I WORK INDOORS	( ) YES ( ) NO	**I PLAY SPORTS**	( ) YES ( ) NO
I WORK OUTDOORS	( ) YES ( ) NO	**I READ A LOT**	( ) YES ( ) NO
I AM A TEACHER	( ) YES ( ) NO	**I LIKE NEEDLE WORK**	( ) YES ( ) NO
I USE A COMPUTER ALL DAY	( ) YES ( ) NO		
I AM A TRUCK DRIVER	( ) YES ( ) NO		

PATIENT HISTORY

PATIENT NAME: _____

PHARMACY & LOCATION: _____ **PHONE #:** _____

PRIMARY CARE PHYSICIAN: _____ **PHONE #:** _____

LAST EYE EXAM: _____

GLASSES HISTORY	CONTACT LENS HISTORY
☐ I CURRENTLY WEAR GLASSES	☐ I WEAR CONTACTS
☐ I NEED COMPUTER GLASSES	☐ BRAND:
☐ I DO NOT WEAR GLASSES	☐ SOLUTION:

PATIENT VISION HISTORY (PLEASE CHECK ANY THAT APPLY)

- ☐ BLINDNESS
- ☐ BLURRED VISION AT A DISTANCE
- ☐ BLURRED VISION AT NEAR
- ☐ CATARACTS
- ☐ COLOR BLINDNESS
- ☐ DIABETIC RETINOPATHY
- ☐ DOUBLE VISION
- ☐ DROOPING EYELID(S)
- ☐ DRYNESS
- ☐ EYE PAIN/SORENESS
- ☐ EYE TURN/LAZY EYE
- ☐ FLASHES OF LIGHT
- ☐ FLOATERS/SPOTS
- ☐ GLAUCOMA
- ☐ HALOS
- ☐ LOSS OF SIDE VISION
- ☐ MACULAR DEGENERATION
- ☐ PATCHING
- ☐ PREVIOUS CORNEAL ULCER
- ☐ PREVIOUS RETINAL BREAKS
- ☐ RED/BURNING ITCHY/ALLERGY EYES
- ☐ SENSITIVITY TO LIGHT/GLARE
- ☐ STRABISMUS (CROSSED EYE)
- ☐ SUDDEN LOSS OF VISION

SURGICAL HISTORY - EYE SURGERIES

☐	
☐	
☐	
☐	
☐	

PATIENT MEDICAL HISTORY (PLEASE CHECK ANY THAT APPLY)

- ☐ ADHD
- ☐ ANEMIA
- ☐ ANXIETY DISORDER
- ☐ ARTHRITIS
- ☐ ASTHMA/COPD
- ☐ AUTISM
- ☐ AUTOIMMUNE DISEASE
- ☐ CANCER

TYPE: _____

- ☐ DEPRESSIVE DISORDER
- ☐ DIABETES
- ☐ EPILEPTIC/SEIZURE
- ☐ HEART DISEASE
- ☐ HIGH BLOOD PRESSURE
- ☐ HIGH CHOLESTEROL
- ☐ HIV
- ☐ INSOMNIA
- ☐ KIDNEY DISEASE
- ☐ LUPUS
- ☐ MIGRAINES/HEADACHES
- ☐ MULTIPLE SCLEROSIS (MS)
- ☐ NURSING MOTHER
- ☐ POSITIVE COVID RESULTS IN PAST 14 DAYS
- ☐ PREGNANT
- ☐ STROKE RISK
- ☐ THYROID DISEASE

SURGICAL HISTORY - OTHER SURGERIES

☐	
☐	
☐	

FAMILY HISTORY (PLEASE CHECK ANY THAT APPLY)

FAMILY VISION HISTORY

- ☐ BLINDNESS
- ☐ CATARACTS
- ☐ COLOR BLINDNESS
- ☐ DIABETIC RETINOPATHY
- ☐ DROOPING EYELID (S)
- ☐ EYE TURN/LAZY EYE
- ☐ GLAUCOMA
- ☐ MACULAR DEGENERATION
- ☐ OTHER:
- ☐ OTHER:
- ☐ OTHER:

FAMILY MEDICAL HISTORY

- ☐ ARTHRITIS
- ☐ ASTHMA
- ☐ AUTOIMMUNE DISEASE
- ☐ CANCER
- ☐ DIABETES
- ☐ HEART DISEASE
- ☐ HIGH BLOOD PRESSURE
- ☐ HIGH CHOLESTEROL
- ☐ HIV
- ☐ LUPUS
- ☐ MULTIPLE SCLEROSIS (MS)

CURRENT MEDICATIONS

	MEDICATIONS	DOSAGE
☐		
☐		
☐		
☐		
☐		
☐		
☐		

ALLERGIES

☐	
☐	

TODAY'S DATE: _____

PATIENT NAME: _____
PATIENT D.O.B: _____

CONTACT LENS EVALUATION AGREEMENT

Contact lenses are medical devices placed on the eyes that require expert fitting and evaluation. They require care and compliance with recommended follow-up examinations to maintain the healthy function of your eyes. The contact lens EVALUATION aims to find the most appropriate contact lens for your optimal comfort and vision. Payment for the **EVALUATION** will be made on the day of your initial visit. Your **EVALUATION** service fee is in addition to your Comprehensive Exam fee. Once the contact lens prescription is finalized, contact lenses may be purchased separately.

Our contact lens **EVALUATION** fees start at **$119.00.** The **EVALUATION** fee may change due to the complexity of the type of **EVALUATION** you are in for.

The same fee applies if your prescription does not change. Contact lens prescriptions must be finalized within 60 days, or a new **EVALUATION** fee will apply. ***Some insurance plans may waive or cover all or a portion of this fee.***

_____ _____

Patient Signature Parent/Guardian Signature

DILATION

Dilation involves using eye drops to enlarge the pupils, allowing us to examine the internal health of your eyes. A dilated fundus exam provides our doctors with the clearest view of the inside of your eyes, which is essential in preventing and addressing eye health issues. Dilation is typically recommended during your initial exam for baseline measurements. It should be performed annually if you have any ocular or medical conditions, including diabetes, glaucoma, macular degeneration, cataracts, high blood pressure, or other eye-related concerns.

**Risks of Dilation: After dilation, you may experience side effects such as light sensitivity and blurred vision, particularly when reading. Most patients can drive following the procedure, but please let our staff know if you feel uneasy about driving. You should avoid operating heavy equipment while your eyes are dilated. If you prefer, you can complete the dilation part of your Eye Health Exam during a separate visit at no extra cost, allowing someone else to drive you.

**Risks of Not Dilation: Skipping a dilated fundus exam may hinder our doctors from diagnosing and treating potential eye health issues, some of which could remain unnoticed without this examination. By opting out of dilation, you are assuming all the risks associated with our doctors' inability to fully assess your ocular health.

_____I **CONSENT** to Dilation _____I **DECLINE** Dilation _____I **WANT to talk to the Doctor 1st**

OPTOMAP IMAGING – NEW TECHNOLOGY

Our office has the latest in ocular imaging, OPTOS. Please know that this is ***NOT*** in lieu of ***Dilation***. This technology provides a magnified picture of the back of your eye, allowing instant viewing of your retina, optic nerve, and other eye structures in detail. ***The fee for this service is $39.00 and is not covered by your insurance company.***

_____I **CONSENT** (OPTOMAP/**COST $39.00**) _____ I **DECLINE** Imagine _____ I **WANT to talk to the Doctor 1st.**

_____ _____

Patient Signature Parent/Guardian Signature

INSURANCE ACKNOWLEDGMENT –

I acknowledge and understand that I am responsible for all charges for all services rendered to me or any member of my family where I am listed as the responsible party. I certify that the information I provided about my insurance is true and correct. I authorize my doctor to act on my behalf to obtain authorizations from my medical/vision insurance. I authorize my insurance to make payments directly to The Vision Hub, LLC, for any services and/or materials furnished. If I have other insurance coverage not listed above, my signature authorizes The Vision Hub, LLC to act on my behalf to retrieve authorizations for coverage and to bill for services. Although I have requested the office to bill my insurance company on my behalf, I clearly understand that it is still my responsibility to make sure the bill is paid in a reasonable time if, for any reason, all or a portion of my bill is not covered by my insurance company.

_____ _____

Patient Signature Parent/Guardian Signature

PATIENT NAME: _____
PATIENT D.O.B: _____

TODAY'S DATE: _____

CONSENT TO TREAT

I consent to The Vision Hub, LLC's care, diagnosis, and/or treatment provisions. I acknowledge that such consent will remain in effect unless and until I cancel it in writing.

_____ _____

Patient Signature Parent/Guardian Signature

REFRACTION – TO UPDATE A GLASSES OR CONTACT LENS PRESCRIPTION, A REFRACTION MUST BE PERFORMED. NON-COVERED SERVICE FOR SOME MEDICAL PLANS- $40.00

The **REFRACTION** test, also known as the vision test, is an examination that tests an individual's ability to see an object at a specific distance. The test involves looking through a device to read letters or recognize symbols on a wall chart through lenses of differing strength contained within the device. **This test is performed as part of a routine eye examination to determine whether an individual has normal vision.** It is also used to determine the prescription for eyeglasses or contact lenses.

Some **Major Medical Insurance Companies** (BCBS, Medicare, UHC, & others) **DO NOT** cover your exam's "REFRACTION" part. Before starting your exam, we will do our best to inform you if this is a NON-Covered service under your insurance.

If your insurance *denies* this service, your signature states that you understand it is your responsibility to cover this fee.

_____ _____

Patient Signature Parent/Guardian Signature

HIPAA ACKNOWLEDGMENT NOTICE OF PRIVACY PRACTICES

I acknowledge that I have reviewed and have the option for a copy of the practice's Notice of Privacy Practices, which describes how the practice may use and disclose my healthcare information for treatment, payment, healthcare operations, and other described and permitted uses and disclosures. I understand that I may contact the practice with questions or complaints. To the extent permitted by law, I consent to using and disclosing my information for the purposes described in the practice's Notice of Privacy Practices. Below, I authorize the release of my Information to the Individuals I hereby permit. The Vision Hub may release my health care information to MY family/friends/others listed here.

Patient Signature: _____

Parent/Guardian Signature: _____

Patient D.O.B.: _____

Family - Friend List	Relation to Patient

Thank you, The Vision Hub