Welcome to our office

Date: **Email:**

Patient Information			
Name- Last:	First:	MI:	Sex: M or F
Date of Birth:	Social Security Number:		
Address:	City:	State:	Zip
Home Phone:	Cell:	Work:	
Employer/School:	Occupation/Grade:		
Marital Status:	Spouse (if applicable):		
If minor, Parent(s) Name(s):			
Emergency Contact:		Phone:	
Account Responsible (if other than self)			
Name- Last:	First:	MI:	Sex: M or F
Date of Birth:	Social Security Number:		
Address:	City:	State:	Zip
Home Phone:	Cell:	Work:	
Relationship to Patient:			
Insurance			
Vision:	Member Name:		DOB:
	Policy ID#:		
Medical:	Member Name:		DOB:
	Policy ID#:		
Secondary Medical:	Member Name:		DOB:
	Policy ID#:		

Are you interested in contact lenses?

Have you ever worn or are you currently wearing contact lenses?

If yes, what kind? What kind of solution are you using?

How many nights per week do you sleep in your contacts?

What other family members are patients here?

Who may we thank for referring you to our office?

Original Date:
Dates Revised:

HEALTH HISTORY QUESTIONAIRE

Name *(Last, First, M.I.)*:

PERSONAL EYE RELATED HISTORY

Check if you have or have had, any of the following areas to a significant degree.

☐ Glaucoma	☐ Blindness	☐ Flashes
☐ Headaches or Eye Strain	☐ Amblyopia (Lazy Eye)	☐ Floaters
☐ Glare/Light Sensitivity	☐ Age Related Macular Degeneration	☐ Redness/Swelling/Discharge
☐ History of Eye Injury	☐ History of Eye Infection(s)	☐ Surgery Related to the Eye
☐ Allergies	☐ Dryness	☐ Other (Please Explain)_________________

PERSONAL MEDICAL HISTORY

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐ Constitutional (Overall Health)	☐ Gastrointestinal (Stomach/Intestinal)	☐ High Blood Pressure
☐ Neurological (Migraines etc.)	☐ Endocrine (Glands)	☐ Diabetes
☐ Ears, Nose, Throat	☐ Genitourinary (Genital/Urinary)	☐ Thyroid Problems
☐ Psychiatric (Mental Health)	☐ Musculoskeletal	☐ High Cholesterol
☐ Cardiovascular	☐ Integumentary (Skin)	☐ Currently Pregnant
☐ Respiratory (Lungs)	☐ Hematologic/Lymphatic (Blood)	☐ Other (Please Specify)

List your prescribed drugs and over-the-counter drugs, such as vitamins, supplements and eye drops		

Allergies to medications

Please list all allergies to medications:

Alcohol	Do you consume alcohol?	☐ Yes	☐ No
	How often?		
Tobacco	Do you use tobacco?	☐ Yes	☐ No
	How often?		
Drugs	Do you currently use recreational or street drugs?	☐ Yes	☐ No

FAMILY HEALTH HISTORY

Check if someone in your immediate family has or has had, any of the following areas to a significant degree. Please list their relation to you.

☐ Glaucoma	☐ Blindness	☐ High Blood Pressure
☐ Diabetes	☐ Lazy Eye	☐ Cancer
☐ Heart Condition	☐ Age Related Macular Degeneration	☐ Thyroid Disorder

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have reviewed a copy of this office's Notice of Privacy Practices. Copies are available upon request.

➡ Please Print Name____

➡ Signature____ Date____________________________

You May Refuse to Sign This Acknowledgement

PERMISSION TO BILL INSURANCE

I give Insight Vision and its affiliated providers permission to bill my insurance for covered services and to exchange information necessary to secure payment for these services. I understand that if an insurance payment is made directly to me for services rendered or materials provided by Insight Vision, I am responsible for immediately sending such payments to Insight Vision. I also understand that I am responsible for any remaining balance not covered by my insurance company including balances that are applied towards my health insurance deductible, co-pays, co-insurance and outstanding balances incurred due to denial by my insurance company. I further understand that some services provided by Insight Vision may or may not be submitted to my health insurance due to the nature of my visit. Benefits quoted are not a guarantee of payment and will be subjected to insurance company's policy. Co-payments and payments for services rendered not covered by insurance are expected at the time of service.

➡ Signature____ Date___________________________

CONTACT LENS EVALUATION AND INFORMATION

Each patient who wishes to wear contact lenses must have a contact lens evaluation with their vision exam every year. These evaluations include specific corneal measurements and tear analysis in order for the doctor to fit them in the best lenses for their eye health and vision needs. There will be an additional charge for these services**; THE ADDITIONAL CHARGE IS NOT USUALLY COVERED BY INSURANCE.** Each contact lens fitting includes 90 days of follow-up care and trial lenses. The 90 day follow-up care is designed to determine and finalize the contact lens fit. After 90 days there will be an extra charge for contact lens visits and trial lenses.

USE AND ADJUSTMENT OF PREVIOUSLY WORN FRAMES

We are happy to make new prescription lenses for your own frame or make adjustments if it is in good condition. If we accept your frame for use, we pledge to take the utmost care in handling it. In a small percentage of cases, the frame material will be worn or brittle due to age or wear. In these cases, the frame may not support a new pair of lenses or an adjustment. Replacement parts are usually not available. If your frame breaks during our insertion process, the lenses we made for your frame cannot be placed into a different style frame. The cost of the replacement frame is your responsibility. In the rare occasion that your frame would break during an adjustment, you would need to inquire about any warranties at the place of purchase.

DUTY TO WARN

We encourage all of our patients to consider ordering lenses made of impact resistant material such as polycarbonate or Trivex to protect their eyes from the unexpected. One of the most common ways that spectacle lenses are broken is in automobile accidents. Rapid inflation of the air bags can strike the face causing the spectacle lens to break. Impact resistant lenses are also important for people who work around machinery, participate in dangerous hobbies, sports enthusiasts, small children, and active teenagers and any patient with only one functioning eye. By signing below you indicate that you have read and understand the risks in purchasing and wearing lenses made from materials other than polycarbonate or Trivex.

COMMUNICATION OF PROTECTED INFORMATION

If you elect to receive information via e-mail, you understand that our e-mail is not encrypted or secure and that your medical information is not protected. If you provide your e-mail address, you acknowledge that you understand any transmission made through e-mail is not secure and could be subject to a security breach. Your signature below indicates you authorize us to discuss protected medical information with you by telephone or through e-mail.

Please sign acknowledging that you have read and understand the information in the preceding three sections.

➡ Signature____Date____________________________

Patient Name:____D.O.B:____________________

Troy Albrecht, O.D.
Douglas Hand, O.D.
Lori Digmann, O.D.
Alaina Blake, O.D.
Laura Purdue, O.D.

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Marion, IA 52302
Tel. 319-377-5343
Fax 319-447-6119

1350 E. Hickman Rd.
Waukee, IA 52302
Tel 515-221-9195
Fax 515-221-9196

I authorize Insight Vision to release/discuss my medical records to/with the following person(s): (You will need to list parents, children, spouse if you authorize us to release any information about you to them. This includes copies of spectacle or contact lens prescriptions, receipts, etc.) This authorization expires 3 years from the date signed. You can revoke this authorization at any time by giving us written notice.

NAME______________________________PHONE__________________RELATIONSHIP____________

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NAME______________________________PHONE__________________RELATIONSHIP____________

NAME______________________________PHONE__________________RELATIONSHIP____________

NAME______________________________PHONE__________________RELATIONSHIP____________

NAME______________________________PHONE__________________RELATIONSHIP____________

Signature:____Date:_______________

CONFIDENTIALITY NOTICE: This message is intended only for the purpose for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential, and exempt from disclosure under applicable law. If the reader of this message is not the intended recipient or the employee or agent responsible for delivering this message to the intended recipient, you are hereby notified that dissemination or copying of this communication is STRICTLY PROHIBITED. If you have received this communication in error, please notify us immediately by telephone and return the original message to us at the above address via U.S. Postal Service. Thank you.