

Welcome To Total Vision ~ www.totalvisioneyecare.net

Name _____ Date _____
Address _____ Phone # _____
City, Zip _____ Cell # _____
Email Address _____ Birthday ___/___/___ Age _____
Occupation _____ Employer _____

Vision Insurance co. _____ insured/relationship _____
Plan/ Group # _____ SSN of Insured _____ - _____ - _____
Medical Insurance co. _____ insured/Relationship _____
Plan/Group # _____ SSN of Insured _____ - _____ - _____

Referred by: ___ Friend ___ Yellow Pages ___ Insurance ___ Web Page ___ Other
Date of Last Eye Exam _____ Location of Last Exam _____
Purpose of Today's exam _____

Have you ever had any eye surgeries, injuries or infection? _____
Do any eye diseases run in your family? _____
Have you had any major surgery or chemotherapy? _____
When was your last health exam? _____
Are you being treated for any health conditions? _____

If you use a computer, how many hours/day? _____
Are your eyes sensitive to sunlight? _____
Do you have prescription sun wear? _____
Do you like to fish? _____ Golf? _____
Interested in Laser Vision Correction? _____ Contacts? _____

Dilation is part of a full comprehensive eye exam, it allows the Doctor to check the health of your eyes. There are NO additional charges to having your eyes dilated.

I would like to be Dilated today: _____ yes _____ no _____ reschedule _____ not sure

A Visual Field Screening will allow the Doctor to check your field of vision (i.e. central and peripheral vision) The screening procedure is \$15.00 and is not covered by most insurance plans.

I would like to have Visual Field Screening: _____ yes _____ no _____ not sure

Eye Screen Photography is an actual photo of the inside of your eyes. It can assist the doctor in early detection of eye health conditions. Eye screen photography is \$29.00 and is not covered by most insurance plans.

I would like to have Eye Screen Photography: _____ yes _____ no _____ not sure

(OVER)

ALL CONTACT LENS PATIENTS: If you are being fit for contacts, we will require at least one follow up visit after your initial fit to check the health of your eyes, the vision and fit of the contacts lenses. Follow up visits are included in the fitting fees at no additional charge for 60 days. After 60 days or refitting another lens mid year will require additional office charges. Your contact lens prescription is available after the fitting process is complete and is valid for up to one year.

CONTACT LENS EXAMS FOR MINORS

My child, under the age of 18, has permission to be fitted for contact lenses.

Parent Name (print): _____

Parent Signature _____

Date: _____

IMPORTANT FOR USING INSURANCE COVERAGE ON TODAY'S VISIT:

Insurance cards should be presented at the beginning of the exam and *cannot* be accepted after the date of service. Please be advised your insurance coverage is between you and your insurance company. If your insurance company has not reimbursed our office in full within 90 days, your credit card will be utilized and your insurance company will then pay you directly. (If by mistake you insurance company sends the payment check to us, we will of course forward the money to you.)

Please enter your credit card number and expiration date.

CC#: _____

Expiration date: _____

Signature: _____

All professional fees are non-refundable.

All fees are due when services are rendered. There is a \$35.00 returned check fee.

Today's fee will be paid by: (circle)

CASH CHECK VISA MASTERCARD DISCOVER AMEX

HIPAA

We are required by federal and state law to maintain the privacy of your health information. We may disclose your information to another healthcare provider to coordinate treatment, payment and healthcare operations. This means insurance items and appointment reminders. Please read our Notice of Privacy Practices while waiting for your exam or request a copy for home.

(Initial): _____ I acknowledge that Gorlin Eye Associates, PC and Total Vision may use and disclose my personal health information to carry out treatment, payment, referral and insurance only. We do not sell or share your information.

MUST SIGN TO BILL INSURANCE.

I have read all the above and understand the above obligations concerning fees, payment, HIPAA and contact lenses.

Patient Name (print): _____ Date: _____

Patient Signature: _____

Total Vision
 Gorlin Eye Associates
 875 Lawrenceville Suwanee Rd
 Lawrenceville, GA 30043

Patient Medical History Record

In an effort to better serve you, we ask that you complete this survey as accurately as possible. Please answer all questions. Thank you.

Today's Date: _____ / _____ / _____

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

Occupation: _____ Medical Doctor: _____

Allergies: List all known allergies.

Penicillin: Yes No Sulfa: Yes No Iodine: Yes No Seasonal allergies: Yes No
 Pain med: Yes No Type: _____ Other (please list): _____

Medications: Please list below (or provide a list of) all medications, including eye drops & non-prescription drugs.

Review of Systems:

Do you currently have any of the following problems?

	Yes	No	If YES, please explain:
Heart Problems (chest pain, irregular heart beat)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory Problems (shortness of breath, wheezing, cough)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gastrointestinal Problems (heartburn, abdominal pain, diarrhea)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Urinary Problems (pain or discomfort, blood in urine)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin Problems (rashes, excessive dryness, rosacea)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Musculoskeletal Problems (muscle aches, joint pain, swollen joints)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurologic Problems (numbness, weakness, headaches, paralysis)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric Problems (depression, anxiety)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic fever, unexpected weight loss/gain, fatigue	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ear/nose/throat Problems (hearing loss, sinus problems, sore throat)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Endocrine Problems (diabetes, thyroid problems)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye injury: previously <input type="checkbox"/> currently? <input type="checkbox"/>			explain: _____

Have you or immediate family member (parent, grandparent, sibling) ever had any of the following conditions?

	Self	Family		Self	Family		Self	Family
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Crossed/Lazy Eye	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Retinal Detachment	<input type="checkbox"/>	<input type="checkbox"/>	Heart arrhythmia	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>
Retinal Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Blindness	<input type="checkbox"/>	<input type="checkbox"/>				Migraines	<input type="checkbox"/>	<input type="checkbox"/>
						Seizures/Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
						Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
						Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
						Cancer	<input type="checkbox"/>	<input type="checkbox"/>
						Liver disease	<input type="checkbox"/>	<input type="checkbox"/>

Surgeries: List any previous surgeries, including eye surgeries and laser procedures:

Do you smoke? Yes No If YES, how much? _____

Do you drink alcohol? Yes No If YES, how much? _____

Are you using or have you ever used recreational (including IV) drugs? Yes No

Date	Intern's Initials	Doctor's Initials
_____	_____	_____
_____	_____	_____
_____	_____	_____

Signature: _____