Wegner Vision Clinic, S.C.

PATIENT INFORMATION

First Name _____ MI _____ Last Name _____

Address _____ City _____ State: _____ Zip _____

Home Phone _____ Work _____ EXT _____ Cell _____

May Wegner Vision leave a message on your voice mail/answering machine regarding appointments arrival of glasses or contacts? Yes _____ No _____ At Home _____ At Work _____ Or Cell _____

Date of birth_____ Social Security Number _____ Sex Male _____ Female _____

Marital Status Single _____ Married _____ Divorced _____ Widowed _____ Separated _____

If a Student: Are you full time _____ Part time _____ Name of School _____

Are you Employed? Yes _____ No _____ Name of Employer _____

How did you choose our Clinic? ___ Phone book ___ Insurance ___ Family Doctor ___ Internet ___ Website ___ Friend/Coworker ___ Newspaper Ad ___ Other (please list) _____

Whom may we thank for referring you too our Clinic? Name _____

RESPONSIBLE PARTY INSURED INFORMATION

Are you the Responsible Party/insurance holder? Yes _____ No _____ If no, your relationship with the Responsible Party: Spouse _____ Dependant _____ Other (please state) _____

First Name _____ MI _____ Last Name _____

Address _____ City _____ State: ___ Zip _____

Home Phone _____ Work _____ EXT _____ Cell _____

Date of birth_____ Social Security Number _____ Sex Male _____ Female _____

Employer _____

INSURANCE INFORMATION

PLEASE SUPPLY US WITH YOUR INSURANCE CARD OR CARDS TO COPY OR PLEASE FILL OUT THE INSURANCE INFORMATION BELOW. THANK YOU.

Insurance Company _____ Ins. Co. Phone _____

Identification No. _____ Group or Policy No. _____

Insurance Co. Address _____ City _____ State: ___ Zip _____

Is there a Secondary Insurance? Yes _____ No _____ If yes, Please provide Insurance Information.

Insurance Company _____ Ins. Co. Phone _____

Identification No. _____ Group or Policy No. _____

Insurance Co. Address _____ City _____ State: ___ Zip _____

HEALTH HISTORY

Reason for today's visit _____

Date of last Eye Exam _____ Name of Eye Doctor_____

Do you or anyone in your immediate family have a history of the following? (Please check all that apply)

_____ Diabetes _____ Blindness _____ High Blood Pressure _____ Cataracts _____ Glaucoma

_____ Thyroid _____ Heart Condition _____ Turned or Lazy Eye

Please check all of the following conditions that apply to YOU.

_____ Allergies _____ Drug Sensitive _____ Dizziness _____ Light Flashes _____ Stroke _____ Asthma

_____ Frequent Headaches _____ Hay Fever _____ Pregnant _____ Given birth in the last 6 months

Date of last General Exam _____ Physician _____

Please list Medications you are currently taking (or a copy of list) _____

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

Have you ever had the following conditions involving your Eyes: (please check any that apply)

_____ Loss of vision _____ Eye surgery _____ Eye Injury _____ Medical Treatment _____ Severe Pain

_____ Sensitivity to Light _____ Floaters or Spots _____ Poor Distance Vision _____ Poor Near Vision

_____ Eye infections or Disease _____ Double Vision _____ Eye Strain _____ Eyes Burn, Itch or Water

Do you currently wear Glasses? _____ Yes _____ No If yes, when do you wear your glasses? _____

_____ All the time _____ Work Safety _____ Computer Work _____ Reading _____ Driving _____ Other

Have you worn Contacts? _____Yes _____ No Interested in wearing Contacts? _____ Yes _____ No

If yes, what Style? ___ Soft ___ Extended Wear ___ Gas Permeable ___ BiFocal ___ Colored ____ Disposable

AUTHORIZATION

PLEASE READ THE FOLLOWING INFORMATION AND SIGN BELOW

I certify that I have completed the above information to the best of my knowledge. I authorize Wegner Vision Clinic to release any information needed to my insurance company and/or healthcare practitioners for payment of my claims, or treatment. I authorize and request my insurance company to pay directly to Wegner Vision Clinic, benefits otherwise payable to me. I understand that I will be responsible for payment of all services rendered on my behalf or of me dependants behalf. I understand that I am responsible for any collection fees that may occur on my or my dependants account.

I HAVE RECEIVED AND UNDERSTAND THE NOTICE OF PRIVACY PRACTICES, (HIPPA), AND THE FINANCIAL AND COLLECTION POLICIES.

PATIENT SIGNATURE _____ DATE _____

(PARENT SIGN IF A MINOR)