Arlington Vision Therapy
WELCOME TO OUR OFFICE

(Please present your insurance card & driver's license to the receptionist)

Today's date:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Status (circle one)
					Single / Married / Child

Is this your legal name?		If not, what is your legal name?	(Former name):	Birth date:	Age:	Sex:	
❑ Yes	❑ No			/ /		❑ M	❑ F

Street address:	Social Security no.	Cell:
		Home:

P.O. box:	City:	State:	ZIP Code:

Referred to clinic by (please check one box):	❑ Dr.		❑ Insurance Plan	❑ Hospital

Referred by:	❑ Family	❑ Friend	NAME:

Other family members seen here:	NAME:

May we contact you by email? ❑ Yes ❑ No E-mail:

RESPONSIBLE PARTY – PERSON RESPONSIBLE FOR ACCT.

Person responsible for bill:	Birth date:		Address (if different):	Home phone no.:
	/ /			( )
Is this person a patient here?	❑ Yes	❑ No		

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

PRIMARY INSURANCE

Is this patient covered by vision insurance?	❑ Yes	❑ No			
Please indicate primary insurance	❑ VSP	❑ EyeMed	❑ Aetna	❑ Humana	❑ Davis
❑ Tribal Insurance	❑ Self	❑ United Health Care Community Plan (March Vision Care)	❑ Other		

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	ID#.:	Co-payment: $

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child		

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Arlington Vision Therapy or insurance company to release any information required to process my claims. I also acknowledge that I received a copy of Arlington Vision Therapy's Notice of Privacy Practices.

Patient/Guardian signature	*Date*

Medical and Visual Health History

Reason for today's visit: _____

Last vision exam: _____ Results/Findings: □ Glasses □ Contacts □ Cataracts □ Glaucoma □ Other _____

Patient wears: □ Glasses □ Contacts (□ soft □ RGP) □ full time □ driving or watching TV only □ reading only □ occasionally

Has the patient ever had eye surgery? □ No □ Yes if yes, please describe: _____

_____

Has the patient ever had an eye injury? □ No □ Yes if yes, please describe: _____

_____

Does this patient use: Tobacco? □ No □ Yes; Alcohol? □ No □ Light □ Moderate; Recreational Drugs? □ No □ Yes

Is the patient currently experiencing any of the following symptoms? (Check all that apply):

□ Blurry vision far away
□ Blurry vision up close (reading)
□ Difficulty reading
□ Unusual blinking or eye rubbing
□ Watering or bloodshot eyes
□ Pain in or around eyes
□ Itchy feeling in or around eyes
□ Light sensitivity
□ Double vision
□ Dizziness
□ Reading fatigue after 15 minutes or less
□ Frequent loss of place when reading
□ Poor reading comprehension
□ Reversal of words, letters or numbers

Please check if the patient or a related family member has ever been diagnosed with any of the following:

General Health	Patient	Family	**Visual Health**	Patient	Family
Diabetes	□	□	Cataracts	□	□
High blood pressure	□	□	Glaucoma	□	□
High cholesterol	□	□	Amblyopia (lazy eye)	□	□
Heart disease	□	□	Strabismus (eye turn in or out)	□	□
Stroke / Brain injury	□	□	Color Blindness / Deficiency	□	□
Headaches / Migraines	□	□	Macular Degeneration	□	□
Sinus problems	□	□	Blindness	□	□
Rheumatoid arthritis	□	□	Retinal detachment	□	□
Other: _____	□	□	Other: _____	□	□

Please indicate medications patient is currently taking or give receptionist a list to photocopy. Please also indicate any medication, food, substance and/or seasonal allergies.

Current Medications	For what condition?
□ See Separate List	□ See Separate List
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____
7. _____	_____
8. _____	_____

Allergies to Medication:

1. _____
2. _____
3. _____
4. _____

Seasonal Allergies? □ Yes □ No

Food / Substance Allergies:

1. _____
2. _____
3. _____

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Patient/Guardian signature: _____ ***Date***: _____

30-Question Symptom Checklist

Name _____

Date_____ Age_____

After you consider each question, mark the box in the column that applies to the person you are assessing.

	NEVER	SELDOM	OCCASIONAL	FREQUENTLY	ALWAYS	SCORE
Blur when looking at near	0	1	2	3	4	
Double vision, doubled or overlapping words on page	0	1	2	3	4	
Headaches while or after doing near vision work	0	1	2	3	4	
Words appear to run together when reading	0	1	2	3	4	
Burning, itching or watery eyes	0	1	2	3	4	
Falls asleep when reading	0	1	2	3	4	
Seeing and visual work is worse at the end of the day	0	1	2	3	4	
Skips or repeats lines while reading	0	1	2	3	4	
Dizziness or nausea when doing near work	0	1	2	3	4	
Head tilts or one eye is closed or covered while reading	0	1	2	3	4	
Difficulty copying from the chalkboard	0	1	2	3	4	
Avoids doing near vision work such as reading	0	1	2	3	4	
Omits (drops out) small words while reading	0	1	2	3	4	
Writes up or down hill	0	1	2	3	4	
Misaligns digits or columns of numbers	0	1	2	3	4	
Reading comprehension low, or declines as day wears on	0	1	2	3	4	
Poor, inconsistent performance in sports	0	1	2	3	4	
Holds books too close, leans too close to computer screen	0	1	2	3	4	
Trouble keeping attention centered on reading	0	1	2	3	4	
Difficulty completing assignments on time	0	1	2	3	4	
First response is “I can’t” before trying	0	1	2	3	4	
Avoids sports and games	0	1	2	3	4	
Poor hand/eye coordination, such as poor handwriting	0	1	2	3	4	
Does not judge distances accurately	0	1	2	3	4	
Clumsy, accident prone, knocks things over	0	1	2	3	4	
Does not use or plan his/her time well	0	1	2	3	4	
Does not count or make change well	0	1	2	3	4	
Loses belongings and things	0	1	2	3	4	
Car or motion sickness	0	1	2	3	4	
Forgetful, poor memory	0	1	2	3	4	

TOTAL

Arlington Vision Therapy

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ARLINGTON VISION THERAPY

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AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient Name: _____ Date of Birth: __/__/__

INFORMATION TO BE RELEASED **BY:**	INFORMATION TO BE RELEASED **TO:**
_____ Organization/Name	_____ Organization/Name
_____ Street Address City, State, Zip	_____ Street Address City, State, Zip
_____ Phone Fax	_____ Phone Fax

TYPE OF MEDICAL INFORMATION REQUESTED:

☐ Communication between the above named

☐ Complete chart notes

☐ My health information only for the following date(s): _____

☐ My health information relating only to the following treatment or condition: _____

☐ Other: _____

I authorize the professional office of my doctor named above to **release health information or receive health** information identifying me or my child [including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services] under the following terms and conditions:

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization form.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed at the top of this form.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Patient Signature: _____ Date: _____

Parent or Legal Guardian _____ Date: _____

Relationship to patient, if other than patient _____
(You may be required to provide legal documentation as proof for power of attorney or guardianship)