ROOSEVELT VISION CLINIC

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Welcome Sheet

Today's Date _____

The information below is confidential, as well as required by insurances and HIPAA

Patient Information

Last Name _____First Name _____ MI _____ Preferred Name _____

Mailing Address _____City _____ State_____ Zip _____

Home Phone # _____Work Phone # _____ Cell Phone # _____ OK to text? YES / NO

Preferred method of communication: ☐ Postal ☐ Telephone ☐ E-Mail Address _____

Gender: M F Birth Date _____ Age _____ Social Security # _____

Are You: Minor Single Married Divorced Widowed Other _____

*If under 18 years of age, who may be attached to the account? ☐ Mother ☐ Father ☐ Other _____

Employer_____ Occupation_____

Preferred Language: ☐ English ☐ Spanish

Race: ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American

☐ Hispanic ☐ Native Hawaiian/Other Pacific Island ☐ White

Emergency Contact Name_____ Relationship_____ Phone #_____

Spouse Name _____ Date of Birth _____

Responsible Party

Name of person responsible for this account _____ Date of Birth _____

Relationship to patient _____ Phone # _____

Mailing Address _____ City _____ State _____ Zip _____

Employer _____ Work Phone # _____ Social Security # _____

Insurance Information (Your services may be covered by health or medical insurance)

PRIMARY INSURANCE	SECONDARY INSURANCE
Medical Insurance:	Medical Insurance:
Vision Insurance:	Vision Insurance:
Policy Holderôs Name:	Policy Holderôs Name:
Date of Birth: Social Security#	Date of Birth: Social Security #
Gender: M F Relationship to Policy Holder:	Gender: M F Relationship to Policy Holder:
Mailing Address:	Mailing Address:
Employer:	Employer:

More Information Needed, Please Turn Page Over

Personal Medical History

Medical Information

How is your general health? _____ Weight _____ Height _____

Do you take medication for any of these systems? **(Please circle Yes or No)**

Gastrointestinal	Yes / No	**Nervous**	Yes / No	**Endocrine (glands)**	Yes / No
Ears/Nose/Throat	Yes / No	**Urinary**	Yes / No	**Blood/Lymph**	Yes / No
Cardiovascular	Yes / No	**Muscles/ Bones**	Yes / No	**Allergic/Immunologic**	Yes / No
Respiratory	Yes / No	**Integumentary (Skin)**	Yes / No	**Headaches**	Yes / No
High Blood Pressure	Yes / No	**Eyes**	Yes / No	**Mental**	Yes / No

If yes, please list the **medical conditions** that you're taking medication for_____

_____

Diabetes Yes / No_____ Type _____ Date of Diagnosis _____ A1C_____

Other Health Problems_____

Current Medication(s) _____

_____

Allergies to Medication(s) Yes / No Which? _____ Reactions? _____

Have you had any operations? Yes / No

Kind? _____ When? _____

Primary Care Physician**:** _____Date of last Medical Exam: _____

Date your blood pressure was last checked? _____

Alcohol Use Yes / No Tobacco Use Yes / No

Personal Eye Information

Do you have any eye conditions or problems? Yes / No What Kind? _____

Have you had any eye operations? Yes / No Type _____ Date _____

Have you had an eye injury? Yes / No Kind_____ Date_____

Do you or have you had any of the following eye conditions? (Please Circle Yes or No)

Glaucoma	Yes / No	**Cataracts**	Yes / No	**Dry Eyes**	Yes / No
Macular Degeneration	Yes / No	**Retinal Detachment**	Yes / No	**Blurred Vision**	Yes / No
Do you wear Glasses?	Yes / No	**Contact Lenses?**	Yes / No	**Interested in Contacts?**	Yes / No

Additional Information _____

Family History

High Blood Pressure	Yes / No	Relation _____	**Macular Degeneration**	Yes / No	Relation _____
Diabetes	Yes / No	Relation _____	**Retinal Detachment**	Yes / No	Relation _____
Glaucoma	Yes / No	Relation _____	**Cataracts**	Yes / No	Relation _____
Blindness	Yes / No	Relation _____	**Crossed Eyes**	Yes / No	Relation _____

As a service, Roosevelt Vision Clinic will bill your insurance (if applicable). I understand I will be responsible for any uncovered amount. I also understand glasses/contacts must be paid before dispensing. I also understand any unpaid balance will accrue an 18% finance charge annually. I will agree to pay any collection cost and/or a reasonable attorney's fee if any delinquent balance is placed with an agency or attorney for collection or suit or is taken to small claims court. I understand this signature will be scanned document and will be recognized as an electronic signature in a court of law.

Authorized Signature _____ **Date** _____