

OMNI EYE CENTER – LASER VISION

Patient Welcome/Update

Thank you for choosing our practice for your eyecare needs.

(Please Print)

Date: ___/___/___

Name _____ DOB ___/___/___ AGE ___ SEX M / F

Single/Married/Divorced/Widow/Minor (circle one)

Mailing Address _____ City _____ State ___ Zip _____

Home Phone(____) _____ Cell Phone(____) _____ Work Phone(____) _____ ext _____

E-mail _____ Social Security # _____

Occupation _____ Employer _____ Self Employed ___ Student ___

Whom may we thank for referring you to our office? _____

With whom are we allowed to discuss your health information?

Spouse _____ Other _____

Name

Name/relationship

Contact Person's Home Phone (____) _____ Cell or Work Phone (____) _____

If patient is under 18 years of age:

I hereby give consent for Omni Eye Center – Laser Vision to treat (child's name) _____

Parent/Legal Guardian Signature _____ Date ___/___/___

(PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED)

<p>Do you have vision insurance? Yes No</p> <p>1) _____ Vision Insurance Company</p> <p>Do you have medical health insurance? Yes No</p> <p>1) _____ Primary Insurance Company</p> <p>2) _____ Secondary Insurance Company</p>
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<p>Insured's Information:</p> <p>Name _____</p> <p>DOB ___/___/___ SS # _____</p> <p>Employer _____</p> <p>Relationship to patient _____</p> <p><i>(Please present insurance card(s) to receptionist)</i></p>
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I authorize Omni Eye Center – Laser Vision to release any medical information necessary to my insurance company to process this claim. This authorization shall apply to all claims submitted on my behalf or for my dependents.

I authorize payment of medical benefits to Omni Eye Center – Laser Vision. I understand that I am financially responsible to the provider for charges not covered by this authorization (non-covered services) as well as any deductible and/or coinsurance and that payment for these services is expected on the day the service is rendered.

I understand that Drs. Jack, Alissa, and Ryan Melton observe the privacy practices established by the **HIPAA Compliance Acknowledgement**. Copies of the Notice of Privacy Practices are available upon request.

Name _____ Date ___/___/___

Print

Signature

PLEASE FILL OUT BACK PAGE

EYE HEALTH ASSESSMENT FORM

Date of last exam _____ Name of Doctor/Office _____

I currently wear:

- Eyeglasses Computer Glasses Bifocal Lenses
 Reading glasses Prescription Sunglasses Progressive Lenses (“No-line bifocal”)

Are you currently wearing contact lenses? Yes No if yes, what brand? _____

Have you ever worn contact lenses? Yes No if yes, what brand? _____

If not currently wearing contacts, are you interested in contact lenses today? Yes No

Have you had laser vision surgery? Yes No

Would you like to learn more about laser vision procedures? Yes No

Are you sensitive to sunlight or glare? Yes No

Does nighttime driving bother you? Yes No

Do you work at a computer 3 + hours a day? Yes No

Do you feel eye fatigue from close-up work? Yes No

Do you work indoors, outdoors, or both? (Circle one)

Activities/Hobbies: _____

Please check any of the following conditions that apply to you or your eyes:

- | | | | |
|---|---|-----------------------------------|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Decreased vision | <input type="checkbox"/> Dry eyes | <input type="checkbox"/> Eye infection |
| <input type="checkbox"/> Flashes of light | <input type="checkbox"/> Fluctuating vision | <input type="checkbox"/> Watering | <input type="checkbox"/> Iritis |
| <input type="checkbox"/> Light sensitive | <input type="checkbox"/> Poor near vision | <input type="checkbox"/> Burning | <input type="checkbox"/> Mucous discharge |
| <input type="checkbox"/> Gritty feeling | <input type="checkbox"/> Poor distance vision | <input type="checkbox"/> Floaters | <input type="checkbox"/> Eyelid disease |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Loss of vision | <input type="checkbox"/> Glare | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> Double vision | <input type="checkbox"/> Eye Strain | <input type="checkbox"/> Itching | <input type="checkbox"/> Eye pain |

Please list current medications and the condition for which it is being taken:

Current Medication(s):	Condition:	Medication Allergies:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____