HAYDEN VISION

PATIENT HISTORY

NAME _____ DATE _____

CONTACT INFORMATION					
First Name:		SS#:			Gender: M F O
Last Name:		Cell Phone:			DOB:
Occupation:		Home Phone:			Age:
Address:		City:	State:		Zip:
Employer:		E-mail:			
Emergency Contact:		Emergency Phone:			

CURRENT HEALTH			
Allergies?			
Medications? (List all, including over-the-counter, or provide list):			
Are you currently being treated for any medical condition?			
Smoke? How Much?	YES NO	Alcohol? How Much?	YES NO

MEDICAL HISTORY			
Any family history of eye disease?			
Have you ever been told you have …?			
Glaucoma	YES NO	Diabetes	YES NO
Cataracts	YES NO	High Blood Pressure	YES NO
Retinal Detachment/Disease	YES NO	Heart Disease	YES NO
Lazy Eye/Amblyopia	YES NO	Breathing Problems	YES NO
Eye Surgery	YES NO	Autoimmune Disease	YES NO
Dry Eye	YES NO	Arthritis	YES NO
Eye Injury/Infection	YES NO	Seasonal Allergies	YES NO
Other (please list)			
Preferred Pharmacy			

VISION HISTORY	
When was your last eye exam?	Were you referred to us? YES NO
Referring Person's Name/City:	
How old are your current glasses?	Do you wear contact lenses? YES NO
When do you use glasses? NEVER RARELY CONSTANTLY READING ONLY DISTANCE ONLY	

FINANCIAL AGREEMENT

I agree that in return for services provided to me by the doctors and staff at Hayden Vision, I will pay any balance my insurance does not cover, including deductibles and/or co-payments at the time that services are rendered, or I will make financial arrangements with Hayden Vision to satisfy this obligation. If my account is sent to a collection agency, I agree to pay reasonable collection expenses. If co-payments and deductibles are designated by my insurance plan, I agree to pay them to Hayden Vision. However, I understand that I am primarily responsible for payment of my bill.

AUTHORIZATION TO PERFORM EXAMINATION

I understand that a refraction may be done at the time services are rendered. This test must be performed in order to determine if a new pair of eyeglasses will improve your vision. Per Medicare guidelines (and similar policies with most insurance companies) this service is not a covered benefit. Hayden Vision is not allowed to make exceptions to waive this fee under Federal regulations.

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Hayden Vision may disclose portions of your medical record to persons or corporations under contract for reimbursement of services; to any healthcare provider for continued patient care; and/or to any family member approved by you. By signing this form, you acknowledge that you were offered the opportunity to receive and review a copy of Hayden Vision privacy practices.

YOUR SIGNATURE: _____ **PRINT NAME:** _____

(OR) AUTHORIZED PARTY: _____ **TODAY'S DATE:** _____