Welcome

Dr. Jed Lister, Optometrist

Today's Date:

Patient's Legal Name:

Last: First: MI:

Date of Birth: Social Security No:

Address: City: State: Zip:

Home Phone: Cell Phone: Text Okay? Y / N Email:

Please provide email for any comments or suggestions.

☐ Male ☐ Female ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Occupation / Hobbies:

Are you using insurance today? ☐ Yes ☐ No

Are you here for a contact lens exam today? ☐ Yes ☐ No

Primary Insurance / Person Responsible For Payment

Name of Insured / Guarantor:

Health Insurance Co: Vision Insurance Co:

Employer:

Date of Birth: Social Security No:

Home Phone: Cell Phone: Relationship:

Address (if different from patient):

Secondary Insurance / Person Responsible For Payment

Name of Insured / Guarantor:

Health Insurance Co: Vision Insurance Co:

Employer:

Date of Birth: Social Security No:

Home Phone: Cell Phone: Relationship:

Address (if different from patient):

Due to constant changes and varieties of insurance plans, you will need to present your insurance card to the receptionist each time you visit our office.
If you do not have your card, please expect to pay for that visit. When insurance information is received, we will file for you.

Medical History

Dr. Jed Lister, Optometrist

Name:

Date of Birth:

List Current Medications (including eye medication):

Any Medication Allergies?

Last Eye Exam:

Do You Currently Wear Glasses or Contacts?

Medical Dr. Name:

Medical Dr. Phone:

Last Medical Exam:

Any known eye disease?

List of medical surgeries?

Are you pregnant or nursing? ☐ No ☐ Yes

Family History

Is there a family history of any of the following? If so, please list their relationship to you.

Blindness ______

Cataracts ______

Crossed Eyes ______

Glaucoma ______

Macular Degeneration ______

Retinal Detachment ______

Arthritis ______

Cancer ______

Diabetes ______

Heart Disease ______

High Blood Pressure ______

Kidney Disease ______

Lupus ______

Thyroid Disease ______

Other ______

Systems Review

Do you currently have or have you ever had any problems in the following areas?

		NO	YES
Constitutional	Fever / Weight Loss / Gain	☐	☐
Cardiovascular / Vascular	Vascular Disease	☐	☐
	High Blood Pressure	☐	☐
Ears / Nose / Mouth / Throat	Allergies / Hay Fever	☐	☐
	Sinus Congestion	☐	☐
Respiratory	Asthma	☐	☐
Gastrointestinal	Diarrhea	☐	☐
	Constipation	☐	☐
Genitourinary	Genitals / Kidney / Bladder	☐	☐
Musculoskeletal	Arthritis	☐	☐
Integumentary	Skin	☐	☐
Neurological	Headaches	☐	☐
	Migraines	☐	☐
	Seizures	☐	☐
Endocrine	Diabetes	☐	☐
	Thyroid / Other Glands	☐	☐
Hematologic / Lymphatic	Anemia	☐	☐
	Bleeding Problems	☐	☐
Eyes	Loss of Vision	☐	☐
	Distorted Vision	☐	☐
	Loss of Side Vision	☐	☐
	Itching	☐	☐
	Burning	☐	☐
	Foreign Body Sensation	☐	☐
	Excess Tearing / Watering	☐	☐
	Glare / Light Sensation	☐	☐
	Chronic Infection of Eye Lid	☐	☐
	Sties or Chalazion	☐	☐
	Flashers / Floaters in Vision	☐	☐

Do you use eye drops?
☐ No ☐ Yes What type? ______

Do your eyes feel dry, painful, or sore?
☐ Never ☐ Sometimes ☐ Often ☐ Always

Do you ever experience episodes or periods of blurred vision?
☐ Never ☐ Sometimes ☐ Often ☐ Always

How often do your eyes feel tired?
☐ Never ☐ Sometimes ☐ Often ☐ Always

Do you have problems with your eyes when you are working on a computer, watching TV or reading?
☐ Never ☐ Sometimes ☐ Often ☐ Always

Social History

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

☐ **Yes, I would prefer to discuss my Social History with the doctor.**

Do you drive? ☐ No ☐ Yes—if yes, do you have visual difficulty when driving?

Do you use tobacco products? ☐ No ☐ Yes
If yes, type, amount, and how long? ______

Do you use / drink alcohol? ☐ No ☐ Yes
If yes, type, amount, and how long? ______

Do you use illegal drugs? ☐ No ☐ Yes
If yes, type, amount, and how long? ______

Have you ever been exposed to or infected with:
☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis

Dr. Jed Lister, Optometrist

DESERT VIEW EYECARE

435-465-2230 Fax 435-673-2272
15 S. River Road, Suite 150, St. George, Utah 84790

Acknowledgement of Receipt of Notice of Privacy Practices

I, ______________________________ hereby acknowledge that I have received the Notice of Privacy Practices of Desert View Eyecare.

______________________________ OR ______________________________
(Signature of Patient) (Signature of Personal Representative)

______________________________ ______________________________
(Date) (Relationship of Personal Representative to Patient)

Patient Payment Responsibility
Please read all the information below carefully. This is a binding legal document.

Patient Payment Liability (Insured)
I acknowledge that the insurance card and information provided with each visit is the correct and current information. I understand that it is my responsibility to inform Desert View EyeCare if a change in my insurance coverage occurs. I understand that not having the current billing information inhibits Desert View EyeCare from billing the services rendered on my behalf in a timely manner. If my insurance has a deductible, I understand it is my responsibility to inform Desert View EyeCare about the deductible amount and if the deductible has been met. I understand that I am legally responsible for all charges incurred whether or not they are paid by my insurance and that any unpaid balance shall be due in full IMMEDIATELY if insurance proceeds are paid directly to me. In the event of default, I agree to pay all cost of collection and reasonable attorney's fees.

Patient Payment Liability
All Professional Fees are due at time of service. I also understand that I am legally responsible for all charges incurred. I also understand that any unpaid balance shall be paid in full immediately. I also agree and understand that all professional fees are non-refundable such as eye exams and contact lenses fittings/follow-ups.

Benefits Assignment Agreement
I hereby give authorization for payment of insurance to be made directly to Desert View EyeCare. I authorize Desert View EyeCare to apply for benefits on my behalf for covered services rendered by Desert View EyeCare.

Release of Information
I authorize the release of any medical information necessary to process claims. I also authorize the release if my medical records, inclusive of all results of my testing and other pertinent information acquired during my treatment to other physicians as deemed necessary. I understand that I may revoke this consent at any time, except to the extent that the action has been taken in reliance thereon in writing to Desert View EyeCare.

Consent for Treatment
I understand my right to participate in my treatment process. I am mentally competent and do hereby consent to necessary examination, procedures, and/or treatments prescribed by my physician, his/her assistants or designees as is necessary in his/her judgment.

By Signing below, I am indicating my understanding of the above information. I agree that a photocopy of this authorization shall be considered as effective and valid as the original. I verify that the above demographics and insurance information is correct. I also agree to update this form with any changes as they occur.

______________________________ OR ______________________________
(Signature of Patient) (Signature of Personal Representative)

______________________________ ______________________________
(Date) (Relationship of Personal Representative to Patient)