VISION 2020 PLLC

Dawn Agostini OD | Ed Sauble OD
Nagaraju Kemidi OD | Stan Bowser OD

Name _____ Date of Birth _____
Mailing Address _____
City_____ State _____ Zip Code _____
Home phone_____ Cell phone_____
Email _____ SSN _____ - _____ - _____

Employer _____ Occupation _____
How were you referred to us? _____

Medical Insurance _____ ID# _____
Member Name _____ DOB _____

Vision Insurance _____ ID# _____
Member Name _____ DOB _____

Vision 2020 participates in most vision/medical insurances, any copays, deductibles and/or out of pocket balances will be the patient's responsibility.

Your vision is our main concern here at Vision 2020 and we work hard to ensure your glasses are made correctly and according to your prescription. Although we do not give refunds on your eyeglass orders, we will remake them at no charge if for any reason the doctor changes your prescription or the lenses were fit incorrectly. Please call us or stop in at your earliest convenience with any questions or concerns.

Signature _____ Date _____
(Patients under 18 must be signed by a parent or legal guardian)

HIPAA COMMUNICATION AUTHORIZATION

Patient's Name _____Date of Birth _____

Persons authorized to receive any personal, medical and billing information via phone, email or text on your behalf:

_____ _____
_____ _____
_____ _____

Signature _____ Date _____
Patient/Parent/Guardian

Patient Name: _____ DOB _____

General Medical History (Check All That Apply)

Name of Medical Doctor _____

Diabetes (When Diagnosed _____)	____	Asthma	____
High Blood Pressure	____	Emphysema	____
Heart Disease	____	Migraines	____
Carotid Artery Disease	____	Cancer	____
Thyroid: HYPO or HYPER?	____	Lupus	____
Irritable Bowel Syndrome	____	HIV+	____
Arthritis: Rheumatoid or Osteo?	____	Sinus	____
Bleeding Disorder	____	Hepatitis	____
High Cholesterol	____	Pregnant	____
Kidney Disease	____	Lyme Disease	____
Acne Rosacea	____	Depression	____
Sjogren's Syndrome	____	Anxiety	____
Multiple Sclerosis	____		

Other conditions not mentioned _____

_____

List any operations and hospitalizations with approximate dates:

_____

_____

Medications (include prescription medicines, eye drops, vitamins, herbals, and over the counter medicines_____

_____

_____

Allergies to:

Medications	YES	NO	_____
Eye Drops	YES	NO	_____
Other (Environmental)	YES	NO	_____

Eye History: (Check All That Apply)

Glaucoma	____	Cataracts	____
Lazy Eye	____	Amblyopia	____
Retinal Disease	____	Retinal Detachment	____
Allergies	____	Dry Eye	____

Date of Last Exam _____

Do you wear glasses? YES NO (for distance, near, or both?) _____

Do you wear contact lenses? YES NO (soft or rigid gas permeable?) _____

List all past eye injuries and eye surgeries with approximate dates:

_____

_____

Family History: Relation to Patient (List any other eye or medical conditions in your family)

Glaucoma	YES	NO	_____
Macular Degeneration	YES	NO	_____
Retinal Detachment	YES	NO	_____
Blindness	YES	NO	_____

Social History:

Smoke? Never Former, Quit _____ Years Ago Current (How much?) _____

Drink Alcohol? Never <1 Drink/Day >1 Drink/Day (How much?) _____

Patient's Signature _____ Date _____