WINTER PARK VISION SPECIALISTS

Date _____

WELCOME TO OUR OFFICE

Patient's Name _____ Date of Birth ___-___-_____ Sex M F Height _____ Weight _____

Address _____ Responsible party if minor _____
Street City State Zip
Phone: (Cell) _____ (Work) _____ (Home) _____ E-mail _____

COMMUNICATION PREFERENCES: Please check if you prefer to communicate with us via TEXT ◯ EMAIL ◯ PHONE ◯

Employer _____ Occupation _____ If Student: School _____ Grade _____

IF THIS IS YOUR FIRST VISIT, HOW DID YOU HEAR ABOUT US? (Please Circle All That Apply)

Family Friend Doctor Insurance List Postcard Ad. Other _____ Who may we thank for the referral? _____

HEALTH AND VISION PROFILE

Does computer work affect your vision **Y N** Do you have unusual visual demands _____

Last Eye Exam _____ Family Physician Name _____ Phone _____ Last Medical Exam _____

List all medications currently taking _____

List any drug allergies _____ List any environmental allergies _____Do you smoke Y N Quit

Are you Interested in contact lenses today Yes ____ No ____ Never Worn Contact Lenses _____

If you currently wear contact lenses, what is the brand and power? _____

PLEASE CHECK THE FOLLOWING THAT APPLY

	SELF		BLOOD RELATIVE	
	Yes	No	Yes	No
Macular Degeneration	◯	◯	◯	◯
Glaucoma	◯	◯	◯	◯
Diabetes	◯	◯	◯	◯
High Blood Pressure	◯	◯	◯	◯
Cataracts	◯	◯	◯	◯
Crosses Eyes	◯	◯	◯	◯

◯ Headaches ◯ Redness ◯ Eyes Water ◯ Eyes Burn
◯ Spots ◯ Dry Eyes ◯ Eyes Burn ◯ Double Vision
◯ Blur at Near with glasses ◯ Blur at Near without glasses
◯ Blur at Distance with glasses ◯ Blur at Distance without glasses

Major Surgery - Illness? _____ Previous Eye Surgery (type) _____

PAYMENT & INSURANCE INFORMATION

METHOD OF PAYMENT (Please Circle) Insurance Debit Card Credit Card Check Cash Other

Health Insurance _____ _____ _____
(Vision) (Medical) (Social Security Number)

RELEASE OF INFORMATION (HIPPA DISCLOSURE)

I acknowledge that I received the Notice of Privacy Practices (HIPPA) from Dr. Podschun & Dr. Ball-Thomas, which sets forth the ways that my personal health information may be used or disclosed by Dr. Podschun & Dr. Ball-Thomas, and outlines my rights with respect to such information. I understand that I am responsible for my bill. I authorize Dr. Podschun & Dr. Ball-Thomas to release my information to all my insurance carriers and for Dr. Podschun & Dr. Ball-Thomas to act as my agent in helping me obtain payment from my insurance carriers. I authorize payment directly to Dr. Podschun, and permit a copy of this authorization and my medical record provided to my insurance carriers. I understand that I am responsible for any copayments, deductibles, & non-covered services.

_____ _____
Signature (Guardian) Date