Lake County Vision Care
2625 Elisha Ave, Zion IL
847-746-1223

New Patient History Form

Welcome to our office. Privacy of personal information is very important to us. We will only use the information necessary for the optometric services and products we provide.

Patients Name:_____ Today's Date:___/___/_____

Date of Birth:____/____/_____ E-mail Address:_____

Address: _____ Home Phone: _____

City: _____ State:_____ Zip:_____ Cell Phone:_____

Employer: _____ Work Phone: _____

Occupation (or Grade):_____ Social Security #:_____

Major Medical Insurance: _____ Policy /ID #:_____

Policy Holder (Name): _____DOB: ___/___/_____ Group #:_____

PLEASE CHECK PAYMENT METHOD: (FEES ARE DUE AT TIME OF SERVICES RENDERED)

[ ] Cash [ ] Check [ ] Credit Card (Visa, MasterCard, Discover)

[ ] Vision Care Plan (Please Name):_____

WHAT ARE THE MAIN REASONS FOR YOUR APPOINTMENT? (PLEASE CHECK):

[ ] Annual Eye Exam	[ ] Double Vision	[ ] Seeing floating/ spots	[ ] Foreign matter in eyes
[ ] Contact Lens Exam	[ ] Dry eyes	[ ] Watering eyes	[ ] Seeing flashes of light
[ ] Need New Glasses	[ ] Red eyes	[ ] Itching eyes	[ ] Other: _____
[ ] Blurred Vision	[ ] Burning eyes	[ ] Pain with eyes	
[ ] Frequent eyestrain	[ ] Frequent Headaches		

Date of last eye exam: ___/____/_____ Previous Doctor and City: _____

Have you ever worn Glasses (Please Circle): Y/N

Contact Lenses (Please Circle): Y/N Brand/Type: _____

CHECK ANY MEDICAL CONDITIONS THAT APPLY TO YOU:

[ ] Diabetes A1C:_____	[ ] Asthma	[ ] Heart Disease	[ ] Fevers
[ ] High Blood Pressure	[ ] Lung Disease	[ ] Cancer	[ ] Fatigue
[ ] Thyroid Disease	[ ] Arthritis	[ ] Seizures	[ ] Depression
[ ] High Cholesterol	[ ] Vascular Disease	[ ] HIV/Aids	[ ] Allergies: _____

PLEASE CURRENT MEDICATIONS AND DOSAGES:

_____

_____

_____

CHECK ANY EYE CONDITIONS THAT APPLY TO YOU:

[ ] Glaucoma
[ ] Cataracts
[ ] Macular Degeneration
[ ] Crossed eye/Turned eye
[ ] Retinal Detachment
[ ] Lazy eye
[ ] Floaters/Spots
[ ] Blindness
[ ] Other: _____

SOCIAL ACTIVITIES (PLEASE CHECK):

[ ] Alcohol Use (Circle: Rarely, Socially, Weekly, Daily)
[ ] Tobacco Use (Circle: Cigarettes, Cigars, Pipe, Smokeless, Other :_____)
[ ] Former Smoker
[ ] Never Smoker

FAMILY MEDICAL/OPTICAL HISTORY (PLEASE CHECK):

[ ] Diabetes (Circle: Father, Mother, Brother, Sister, Son, Daughter)
[ ] High Blood pressure (Circle: Father, Mother, Brother, Sister, Son, Daughter)
[ ] Thyroidism (Circle: Father, Mother, Brother, Sister, Son, Daughter)
[ ] Cancer (Circle: Father, Mother, Brother, Sister, Son, Daughter)

[ ] Cataracts (Circle: Father, Mother, Brother, Sister, Son, Daughter)
[ ] Macular Degeneration (Circle: Father, Mother, Brother, Sister, Son, Daughter)
[ ] Glaucoma (Circle: Father, Mother, Brother, Sister, Son, Daughter)

PRIVACY POLICY AND INSURANCE AUTHORIZATION AND ASSIGNMENT (PLEASE READ AND SIGN):

I hereby authorize Lake County Vision Care to release information to insurance carriers concerning illness and treatments. I hereby assign the physician[s] all payments for medical services rendered to myself or my dependents. Certain procedures/materials, Medicare and insurance companies consider 'non-covered' and will not pay. I understand that I am personally responsible for those 'non-covered' charges and, if such charges are not paid and require legal action, I am responsible for court costs and attorney fees. I acknowledge that I have read a copy of Lake County Vision Care's Notice of Privacy Practices.

Signature: _____ **Date:** ____/____/_____

FEES ARE DUE UPON SERVICES RENDERED
FEES FOR PRODUCTS ARE DUE UPON ORDERING AND DISPENSING

Vision insurance vs Medical insurance

We often have patients that have both vision and medical insurance. They are very different in terms of the services they cover and it's important for our patients to understand these differences.

Vision insurance is designed mainly to cover determining a prescription for glasses, to help pay for glasses or contact lenses, and to cover a routine evaluation of the health of the eyes in a healthy patient that has no particular problems or symptoms. It is not equipped to deal with and does not usually cover medical conditions and/or treatment plans. Similarly, medical insurance is designed for when you have a medical problem that affects the eyes, and it does not cover routine services or examinations for glasses, or routine vision problems such as nearsightedness, farsightedness, and astigmatism.

When a medical diagnosis or medical condition is present that affects your eyes, such as high blood pressure, high cholesterol, or diabetes, to name just a few examples, or you have an eye disease or eye problem such as an infection (pink eye), dry eyes, allergy, or cataracts, again, just to name a few, we must often file the claim with your medical insurance, and the co-pays and deductibles for that insurance will apply. Your vision plan does not cover these kinds of problems. Our office does not make these rules, they are made by the insurance companies themselves, and we must comply with them.

There is often no way to know prior to your examination which type of insurance will be the right one to file your claim with. We make every effort to include as many insurance panels, both medical and vision, as we can for your convenience. If we are on your insurance company's panel we will file those claims for you. In the event that we do not accept your medical or vision insurance we will provide you with an itemized receipt so that you may file a claim with your insurance yourself for reimbursement. If you have any questions, please let us know.

I understand the information I've just read about the difference between vision and medical insurance and I authorize Lake County Vision Care, PC to file my claim with the appropriate insurance based on the reason for my visit and the results of my examination. If I refuse then I am responsible for any payments due at time of service.

Signed: _____

Date: _____