Center for Vision Development

Patient Information

LAST Name:_____ DOB: _____/_____/_____

FIRST Name: _____

Single: __ Married: __ Widowed: __ Divorced: __ Sex: M F

Address:_____

City: _____ ST: _____ Zip: _____

Student: __ Employed: __ Retired: __ Other: __

Employer Name:_____ Occupation:_____

Race/Ethnicity

White: __
Black/African American __
Asian: __
American Indian/Alaska Native__
More than 1 Race: __
Native Hawaiian: __
Pacific Islander: __
Unreported/Refused to Report: __

Hispanic Latino: __
Non-Hispanic Latino: __
Unreported/Refused to Report: __

Guarantor

Self: __ Parent: __ Spouse: __ Other: _____ DOB: _____/_____/_____

LAST Name: _____

FIRST Name: _____ Sex: M F

Address: _____

City: _____ State: _____ Zip: _____

Home#: ____-____-_____

Cell#: ____-____-_____

Work#: ____-____-_____

Email:
_____@_____

Is it OK to leave a message? Y N
Preferred methods: Circle Two
Home Cell Work Email

Emergency Contact: Name:_____ Phone#: _____-_____-_____

PRIMARY Insurance Co: _____ Policy#: _____ Group#:_____
Policy Holder: Patient___ Guarantor above: ___
OTHER Relation: _____>>> Last Name: _____ First Name:_____ DOB_____

SECONDARY Insurance Co: _____ Policy#: _____ Group#: _____
Policy Holder: Patient___ Guarantor above___
OTHER Relation: _____>>> Last Name: _____ First Name: _____ DOB_____

I was Referred by: Doctor:_____ Phone#: _____-_____-_____

WELCOME TO OUR PRACTICE

Our goal is to provide comprehensive vision care to our patients. Our philosophy is preventative and developmental in approach. To provide services in an efficient manner, please be aware of the following office policies:

*Fees for services are due at the time those services are rendered.
*A deposit is required on all materials when selected, and the balance is due upon delivery.
*A 1.5% service charge per month (18% per year) will be levied on all balances over 30 days old.
*We reserve the right to charge for missed appointments which are not canceled 24hrs in advance.
*A charge of $25, or the legal maximum, will be charged for any check not honored and or returned by your bank.
*If it is necessary to incur legal expenses to collect delinquent accounts, all expenses and court fees will be assumed by the debtor
*We will not file for coverage of any insurance in which we do not participate.
*Extended testing for contact lens fitting and certain vision problems may not be covered under your vision care plan. You will be billed separately for those services not covered.
*Patients are responsible for obtaining referrals, when necessary, from their physician prior to their appointment. If one is not supplied and your insurance does not pay you will be responsible for any charges.

I have read, understand, and agree to the above policies: _____ Date:_____
(Signature of Responsible Party)

Center for Vision Development

Diagnostic and Rehabilitative Vision Care

Health History

Name: _____ Age: _____

Reason for today's visit:

_____

_____

Please fill out all information.

Inform our office when there are any changes in the medical information you provide below.

Eye and vision history:

When was your most recent eye/vision exam? ___/___/___ Dr. _____

Do you currently wear glasses or contacts? ____ All the time ____ Occasionally ____ No

Do you wear them for ____ Reading ____ TV ____ Computer work ____ Driving

Have you ever had eye surgery? Yes No When? _____ Condition _____

Have you ever had the following eye conditions?

___ Sandy or Gritty feeling	___ Distorted Vision	___ Lazy eye/Crossed eye
___ Itching, Burning, Tearing	___ Flashes of light	___ Glaucoma/Cataracts
___ Discharge	___ Increased Floaters	___ Frequent Infections
___ Redness	___ Shadows or Cobwebs	___ Dry eyes
___ Pain or soreness	___ Loss of Sight	___ Glare/Light sensitivity
___ Double Vision	___ Loss of side vision	___ Eye Strain
___ Blurred Vision	___ Foreign body sensation	___ Frequent Styes

Use of Alcohol: ___ Never ___ Rarely ___ Moderate ___ Daily

Use of Tobacco: ___ Never ___ Daily: amount _____ ___ Former smoker ___years

Previous Hospitalizations/Surgeries/Serious illness Month/year

_____ _____

_____ _____

Family Medical History:

Age Medical/Eye Disease

Father __Glaucoma Cataract Macular degeneration Strabismus Amblyopia Diabetes Hypertension

Mother __ Glaucoma Cataract Macular degeneration Strabismus Amblyopia Diabetes Hypertension

Siblings__ Glaucoma Cataract Macular degeneration Strabismus Amblyopia Diabetes Hypertension

Siblings__ Glaucoma Cataract Macular degeneration Strabismus Amblyopia Diabetes Hypertension

Siblings__ Glaucoma Cataract Macular degeneration Strabismus Amblyopia Diabetes Hypertension

Please list other conditions: Keratoconus Fuchs dystrophy Retinitis pigmentosa Color vision deficiency

_____

_____

Center for Vision Development • 164 W. Main Street, Suite B • New Market, Maryland 21774

Office 301-865-1800 • Fax 301-865-1973 • www.centerforvisiondevelopment.net

Please indicate any personal history below: (current past)

Constitutional Symptoms
___ Good general health
___ Recent weight change
___ Fever
___ Fatigue

Hematologic/Lymphatic
___ Anemia
___ Bruising tendency
___ Slow to heal after cut
___ Phlebitis
___ Past transfusion
___ Enlarges glands

Cardiovascular
___ Heart disease
___ Chest pain
___ Palpitation
___ Swelling of feet, hands

Ears/Nose/Mouth/Throat
___ Earaches or drainage
___ Chronic sinus problems
___ Rhinitis
___ Nose bleeds
___ Mouth sores
___ Bleeding gums
___ Bad breath
___ Hearing loss or injury
___ Sore throat

Musculoskeletal
___ Joint pain
___ Arthritis
___ Muscle pains or cramps
___ Fibromyalgia
___ Back pain
___ Cold extremities
___ Difficulty walking

Allergic/Immunologic
___ Penicillin/Sulfa
___ Morphine/Narcotics
___ Novocain
___ Aspirin
___ Tetanus antitoxins
___ Iodine, Merthiolate
___ Animal fur/Dust/Mold
___ Pollen
___ Hay fever/Grass

Neurological
___ Numbness
___ Tingling sensation
___ Paralysis
___ Headaches
___ Light headed or dizzy
___ Head injury
___ Tremors
___ Seizures

Gastrointestinal
___ Loss of appetite
___ Bowel problems
___ Abdominal Pain
___ Frequent diarrhea
___ Nausea or Vomiting
___ Rectal bleeding
___ Eating disorder
___ Ulcer

Other medical conditions:
___ High Blood Pressure
___ Cancer
___ Diabetes
_____
_____
_____

Respiratory
___ Chronic/frequent coughs
___ Shortness of breath
___ Wheezing
___ Coughing up blood
___ Asthma

Psychiatric
___ Memory loss
___ Confusion
___ Insomnia
___ Nervousness
___ Dementia
___ Depression

Drugs/medications taken:
_____
_____
_____
_____
_____

Patient (or guardian)
Signature: _____ Date _____

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Dr. Marsha D. Benshir
Dr. Amber Smith
Center for Vision Development
Diagnostic and Rehabilitative Vision Care

Neuro-Optometric History

Name: _____

Date of onset: _____

Primary diagnosis: _____

Visual symptoms: _____

Other medical conditions: _____

_____

Summary of event: _____

_____

_____

Date of most recent eye exam: _____

Doctor's name/phone number: _____

Glasses worn: ____ Full time ____ As needed ____ No change in prescription

Primary care name/phone number: _____

Neurologist/physiatrist: _____

Current therapies: _____

Is your vision: ____ improving; ____ staying the same; ____ getting worse?

Were you driving prior to onset? ____yes ____no

Were you reading prior to onset? ____yes ____no

Were you using a computer prior to onset? ____ yes ____no

What other activities are limited? _____

_____

_____

What are you goals for vision rehabilitation? _____

_____

_____

Other considerations: _____

_____

_____

Form completed by : _____

Date: _____

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Lifestyle Checklist

Name: _____ Date:_____ ___PRE/___POST

Please assign a value between 0 and 4 for each symptom.

0= never or non-existent / 1= seldom / 2= occasionally / 3=frequently / 4= always

1	Blurred vision at near	
2	Double vision	
3	Headaches associated with near work	
4	Words run together when reading	
5	Burning, stinging, watery eyes	
6	Falling asleep when reading	
7	Vision worse at the end of the day	
8	Skipping or repeating lines when reading	
9	Dizziness or nausea associated with near work	
10	Head tilt or closing one eye when reading	
11	Difficulty copying from the chalkboard	
12	Avoidance of reading and near work	
13	Omitting small words when reading	
14	Writing uphill or downhill	
15	Misaligning digits in columns of numbers	
16	Reading comprehension declining over time	
17	Inconsistent/poor sports performance	
18	Holding reading material too close	
19	Short attention span	
20	Difficulty completing assignments in reasonable time	
21	Saying "I can't" before trying	
22	Avoiding sports and games	
23	Difficulty with hand tools-scissors, calculator, keys, etc.	
24	Inability to estimate distances accurately	
25	Tendency to knock things over on desk or table	
26	Difficulty with time management	
27	Difficulty with money concepts, making change	
28	Misplaces or loses papers, objects, belongings	
29	Car sickness/motion sickness	
30	Forgetful, poor memory	

Dr. Marsha D. Benshir
Dr. Amber Smith
Center for Vision Development
Diagnostic and Rehabilitative Vision Care

Statement of Office Policies-Privacy Notice

This practice is in compliance with HIPAA regulations. Your records are strictly confidential and will not be released for any purpose not specified as related to your care. We do not provide patient lists to any third parties.

With the new changes in health care regulations, we can no longer release copies of records or reports without a signed, written request from the patient, parent, or legal guardian. This includes release of prescription information to any third party.

We will not give prescription information over the phone for any purpose. When any prescription is to be filled outside of our office, the patient will be given a written prescription. Prescriptions may be faxed to a pharmacy or optician with the patient's written permission.

Your insurance plan may not cover all services we provide. If special testing is recommended, you will be responsible for that part of the bill that is not covered by your major medical. This will be billed to you separately.

Reports to other professionals or schools are rarely covered by insurance. The cost of a written reports is not included in the cost of the services. This will be billed separately, and payment is the responsibility of the patient. The exception to this is a report to a referring doctor.

A statement explaining your rights and responsibilities under HIPAA is available in our office. You are welcome to read this at any time. If you would like a copy of our complete HIPAA policy, it will be provided upon request.

This practice is required by Federal law to maintain the privacy of your protected health information (PHI), and to provide you with this Privacy Notice detailing our Practice's legal duties and privacy practices with respect to your PHI.

Under the Privacy Rule, our practice may be required by State law to grant greater access or maintain greater restrictions on the use or release of your PHI than that which is provided for under Federal law.

This practice is required to abide by the terms of this Privacy Notice. This practice reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for your entire PHI that it maintains. This practice will distribute any revised Privacy Notice to you prior to implementation.

This practice will not retaliate against you filling a complaint. This notice is in effect as of April 15, 2003.

By signing my name below, I acknowledge receipt of a copy or this Privacy Notice, and I understand and agree to its terms.

_____ _____

Patient/Parent/Guardian *Date*