PREMIER VISION

DR. KENT WILSON
THERAPEUTIC OPTOMETRIST

Name_____ **Date of Birth**_____

Today's Date_____ **Date of last eye exam, if elsewhere**_____

Reason for visit today _____

Current Height _____ Current Weight _____ Primary Doctor _____

Do you smoke? Yes No If yes, how many packs per day? _____ How many years? _____

Have you used tobacco in the past? Yes No How long ago? _____

Do you use smokeless tobacco? Yes No

Using tobacco products can increase your risk of Macular Degeneration and dry eye.

Do you drink alcohol? Yes No How frequently? _____

Are we allowed to send you messages? (please circle) Home Texting Email

Email Address:

MEDICAL CONDITIONS (circle all that apply)

Arthritis Seasonal Allergies Asthma Anxiety Depression Kidney Disorder Skin Disorder
Thyroid Disorder High Blood Pressure High Cholesterol Cancer (Type) _____

Are you Diabetic? Yes No Date diagnosed _____ Last A1C _____

Is your blood sugar controlled? Yes No What doctor treats your diabetes _____

Other conditions _____

LIST MEDICATIONS OR PROVIDE A LIST (Rx and OVER THE COUNTER)

	Medication	Condition	Dosage	Times Per Day
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

Medications you are allergic to _____

Cataracts or Cataract Surgery Yes No If yes when? _____

Other Eye surgery ? _____ When ? _____

Past Eye Injury? _____ When? _____

FAMILY HISTORY OF:

Blindness Yes No Relationship _____
Macular Deg Yes No Relationship _____
Glaucoma Yes No Relationship _____
Diabetic Retinopathy Yes No Relationship _____
Diabetes Yes No Relationship _____
Heart Disease Yes No Relationship _____
Cancer Yes No Relationship _____ Type of cancer _____

PLEASE READ OUR POLICIES AND SIGN THE OTHER SIDE ——>>

NO SHOW/CANCELLATION POLICY

It is important to be present for your appointment. Not making your appointment inconveniences other patients. Please call us at least 24 hours in advance if you need to move your appointment time or date in order to avoid a $15 cancellation fee. We understand that emergencies do happen, therefore if a patient does not show up for their appointment for 3 consecutive visits or cancels up to 3 times the same day of the appointment, that patient will be seen on a standby basis only.

CONTACT LENS POLICY

Contact lens and/or service fees not covered by insurance must be paid in full at the time of service and are not refundable. Contact lens prescriptions will only be released after the initial fitting period is successfully completed and after all fees are paid. Contact lens are to be paid in full before being ordered. Unused contact lenses are not returnable.

LAB, REFUND, PRESCRIPTION CHANGE POLICIES

New frames normally have a 1 or 2 year warranty from the original order date for manufacture defects only. This warranty does not cover loss. If a patient is unable to adapt to his/her new prescription, please let us know within 60 days. We can make adjustments, but this does not entitle the patient to a refund. First time

FINANCIAL POLICY

Examination fee is due at the time of service. Co-pays, deductibles, and non-covered services or material are due at the time of service. Because of the variety of insurance carriers we submit claims to and the uniqueness of individual policies, we cannot fully know the extent of coverage you may have. We expect payment in full if your insurance company has not paid within 30 to 90 days. NSF checks will be charged a $30 service fee. Accounts with an outstanding balance will be sent to a collection agency after 90 days and may be responsible for collection agency fees.

CONSENT FOR USE OF INSURANCE INFORMATION

I authorize Dr. Wilson to release any information required to process my insurance claim, or insurance claim for my child. I also authorize my insurance benefits be paid directly to Dr. Wilson and understand that I am financially responsible for any non-covered or denied services. Although Dr. Wilson and staff have made every effort to verify my benefits before my appointment, I understand that there is no guarantee of insurance payment and I understand I am financially responsible for all fees not covered by my insurance.

Signed _____ Date _____

I certify that I have read and understand the above policies and have accurately answered all medical questions on the previous page to the best of my knowledge. Any copy of this authorization shall be as valid as the original.

Signed_____ Date_____