Vision Source

708 Hill Country Dr., Suite 100
830-257-5656 • www.visionsource-tilley.com

Last Name _____ **First** _____ **MI** _____**Male / Female**

Mailing Address _____ **City**_____ **State**_____ **Zip**_____

Primary Phone _____ **Cell**_____**Is texting ok? Yes/No**

Email _____ **Date of Birth**_____ **SS#**_____

Employer _____**Occupation**_____**Full Time / Part Time**

Student: Yes/No Married/Single Communication Preference: Email Text Phone Mail

Preferred Language _____ **Race**_____**Ethnic Group**_____

How did you hear about us? _____

Do you currently wear: (Circle all that apply)
Eyeglasses Computer Glasses Sunglasses
Contacts (if so are you happy with current brand of contacts?) YES NO

Are you interested in Contacts: Yes / No Lasik Corrective Surgery: Yes / No

<u>Fill out the Following if you have insurance and are NOT the policy holder</u>

Policy Holder's Full Name _____

SS# _____ **Date of Birth**_____

<u>Responsible Party (If patient is under 18)</u>

Full Name_____ **Date of Birth**_____

SS# _____ **Relationship to Patient**_____

ACKNOWLEDGEMENT OF PAYMENT POLICY:

Examination fee is due at time of service. Any co-payments and deductibles as well as fees for non-covered tests or materials are due at time of service. If we are a provider of your insurance and you have coverage for services or materials, we will submit claims for you. Because of the variety of insurance carriers we submit claims to, and the uniqueness of individual policies, we cannot know the extent of coverage you may have. Your insurance may not provide coverage for some materials and/or services we perform. After 30 days, we will expect payment in full if your insurance company has not paid. Returned NSF checks will be charged a $30 service fee. By signing below I am aware that if my account is not paid within 30 days of date of service it may be sent to collections. I assume all legal fees and services changes incurred if collection action must be taken. ALL sales are final and we do not give refunds for professional fees, glasses or contact lenses for any reason! I have read and agree to the above statements.

X _____

Signature of Guarantor Relationship if not patient Date

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THIS SECTION FOR OFFICE USE ONLY

DR. TILLEY DR. NGUYEN DR. WHITEHEAD

PP NP CL PATIENT ID_____**LAST EXAM**_____

Ocular and Medical Family History. (Please Circle)

Glaucoma- Mom, Dad, Brother, Sister
Macular Degeneration- Mom, Dad, Brother, Sister
Diabetes- Mom, Dad, Brother, Sister
Rheumatoid Arthritis- Mom, Dad, Brother ,Sister

List your chief complaint or reason for today's visit.

_____
_____
_____

Please list ANY medical conditions you have and the date diagnosed.

_____
_____
_____
_____

Please list ANY eye condition/diseases you have and date diagnosed.

_____
_____
_____
_____

Please list ALL <u>Medical and Ocular</u> surgeries you have had including dates.

_____
_____
_____
_____

List all medications you are currently taking along with dosage.
(You may bring in bottles or attach a comprehensive list)

_____
_____
_____

List any medications you are allergic to and the reaction you had. (ie rash, hives, etc)

_____
_____
_____

Primary Care Physicians Name and fax number: _____

Smoking Status: (please circle) Current Smoker Former Smoker Never Smoked

Alcohol Consumption: (please circle) None Less than 1 drink per day
1-2 Drinks per day 3 or more drinks per day

ACKNOWLEDGEMENT
OF
NOTICE OF PRIVACY PRACTICES

The law requires that Tilley Eye Care Centers, LLC make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

- I have read or had explained to me Tilley Eye Care Centers, LLC's Notice of Privacy Practice and agree to continue my care with Tilley Eye Care Centers, LLC under said terms.
- I was given the opportunity to read Tilley Eye Care Centers, LLC's Notice of Privacy Practices and declined but wish to continue my care with Tilley Eye Care Centers, LLC under the terms of Tilley Eye Care Centers, LLC's privacy policies.
- I have read or had explained to me Tilley Eye Care Centers, LLC's Notice of Privacy Practice and do not wish to continue my care with Tilley Eye Care Centers, LLC under said terms.
- The Notice of Privacy Practice could not be read due to the emergent nature of the care or other reason described as

  _____

  _____

Names to whom we can release your medical information (spouse, parent, etc.)

_____

_____

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

_____ _____

Patient Date

If you are signing as a personal representative of the patient, please indicate your relationship

_____ _____

Representative Relationship to Patient

Updated Aug 2016