ATHENS FAMILY VISION CLINIC

CHECK IN_____ CHECK OUT_____

Name ______________________________ Date ____________

Address ______________________________

City ______________ State________ Zip Code____________

Home Phone __________ Work Phone____________ Cell Phone____________

Date of Birth______________ Age__________ Sex M F

Patient SS# ____________ Patient DL# ____________ Are you a student? Y N

Employer ______________________ Occupation ______________

Are you married? Y N Spouse's Name ______________________

Are you currently pregnant? Y N If yes, when are you due? ____________

Medical Insurance* ______________________ Policy # ____________

Policy Holder SS# ______________________ Policy Holder DOB: ____________

Vision Insurance ______________________ Policy # ____________

Policy Holder SS# ______________________ Policy Holder DOB: ____________

*If a medical diagnosis is made at the time of your visit, your medical insurance will be billed in lieu of your vision insurance.

Is today's visit for: GLASSES CONTACTS BOTH EMERGENCY MEDICAL

Do you currently wear: GLASSES CONTACTS BOTH

Hobbies ______________________________

Is most of your driving done during the: DAYTIME NIGHTTIME BOTH

How many hours a day do you spend reading? ________ Working on the computer? ________

Date of Last exam ______________ Where? ______________________

Primary Care Doctor's name ______________________ City ____________

How did you hear about our office? ______________________________

If under 18 years of age, please complete the following information pertaining to the parent or legal guardian of minor:

Guardian Name ______________________ Relationship ____________

Social Security # ____________ DOB ____________ Phone # ____________

Over please

Have you ever been treated for or told that you have any of the following conditions?

	Y	N		Y	N
High blood pressure	☐	☐	Cataracts	☐	☐
Diabetes	☐	☐	Glaucoma	☐	☐
Heart problems	☐	☐	Floaters	☐	☐
Respiratory problems	☐	☐	Vision loss	☐	☐
Cancer	☐	☐	Eye injury	☐	☐
Thyroid disease	☐	☐	Eye surgery	☐	☐
Stroke	☐	☐	Double vision	☐	☐
Headaches	☐	☐	Eye turn	☐	☐
Arthritis	☐	☐	Lazy eye	☐	☐
HIV/AIDS	☐	☐	Allergies	☐	☐

Other conditions not listed above ____________________

Known drug allergies ____________________

Medications you are presently taking ____________________

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WARRANTY POLICY

We want you to love your new glasses! Therefore, if you are not completely satisfied with your new glasses, we will gladly exchange them one time within 30 days of the date of receipt. For one year from your purchase date, if you break your glasses we will replace your broken glasses with a new pair or an equivalently priced pair for 50% of their current retail price (may not be combined with other discounts or insurance). Additional costs will be incurred on any upgrades. This warranty does not apply to loss or theft.

CONTACT LENS POLICY

Open boxes are neither refundable nor returnable. To receive a prescription for contacts, you must have a Contact Lens evaluation. This portion of the exam is not covered by insurance and is an out-of-pocket expense. The initial contact lens evaluation starts at $50 and increases depending on the complexity of the fitting. The evaluation for existing contact lens wearers is $20. The evaluation fee must be paid prior to receiving any contact lenses.

FINANCIAL POLICY

A 50% deposit is required on all orders before orders can be completed.

The patient or guardian is responsible for all charges. If an insurance payment has not been received within 60 days from the date of service, the charges will become the responsibility of the patient. Personal accounts over 90 days past due will be turned over to Collection Services of Athens (706)357-9164) for collection procedures.

- **I authorize the use of this form for all my insurance submissions.**
- **I understand that Athens Family Vision Clinic will file my insurance as a courtesy for me and that for any reason my insurance company does not pay within a reasonable amount of time, or denies charges for any reason, I will be responsible for all charges.**
- **I authorize payment directly to Athens Family Vision Clinic.**
- **I have read and understand this financial policy.**

Signature of Patient/Guardian ____________________ **Date** ____________