

# ATHENS FAMILY VISION CLINIC

CHECK IN \_\_\_\_\_

CHECK OUT \_\_\_\_\_

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Email Address \_\_\_\_\_ 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

Medical Insurance \_\_\_\_\_ Member ID# \_\_\_\_\_ Group# \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_ SS# \_\_\_\_\_ DOB: \_\_\_\_\_

Policy Holder's Address \_\_\_\_\_

Vision Insurance \_\_\_\_\_ Policy # \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_ SS# \_\_\_\_\_ DOB: \_\_\_\_\_

Policy Holder's Address \_\_\_\_\_

\*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 # \_\_\_\_\_

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

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

Family History of any of the conditions listed above \_\_\_\_\_

Other conditions not listed above \_\_\_\_\_

Known drug allergies \_\_\_\_\_

Medications you are presently taking \_\_\_\_\_

**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% non-refundable 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 \_\_\_\_\_