ATHENS FAMILY VISION CLINIC

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. This may result in an additional specialist co-pay due at the time of exam.

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

Do you currently wear: GLASSES CONTACTS BOTH

Hobbies _____

Preferred Language _____ Ethnicity _____

Date of Last exam _____ Where? _____

Primary Care Doctor's name _____ City _____

Preferred Pharmacy _____ Number _____

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 # _____

Please circle any of the following conditions that you ever been treated for or told that you have.

High blood pressure	High Cholesterol	Diabetes
Heart problems	Respiratory problems	Cancer
Thyroid Disease	Stroke	Headaches
Arthritis	HIV/ AIDS	Cataracts
Glaucoma	Floaters	Vision loss
Eye injury	Eye surgery	Double vision
Eye turn	Lazy eye	Allergies
Other: _____	Height: _____	Weight: _____

Family history of any of the conditions listed above? _____

Do you currently smoke? _____ How many per day? _____ How many years? _____

Do you currently drink? _____ How many per day? _____ How many years? _____

Known drug allergies: _____

Medications you are presently taking: _____

_____

WARRANTY POLICY

We want you to love your new glasses! However, if you are not completely satisfied, we will gladly exchange your frame one time and give a 50% discount on the new replacement lenses within 30 days of the receipt date. If your frame or lenses break within the first year from purchase date, we will replace the broken frame or lenses (one time only under manufactures warranty conditions). Warranty does not apply to loss or theft. Any lenses or frame upgrades will require an additional cost. _____ (initials)

OUTSIDE PRESCRIPTIONS

We will gladly accept and make lenses from another doctor's office, however if you are not satisfied with the prescription, you will be responsible for 50% of the lens fees for a prescription change. _____ (initials)

CONTACT LENS POLICY

Open boxes are neither refundable nor returnable. To receive a prescription for contacts, you must have a yearly 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 fee depends on the complexity of the fitting and will be determined after being examined by the doctor. The evaluation fee must be paid prior to receiving any contact lenses. _____(initials)

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** _____