Dr. CARL VINSON
OPTOMETRIST

Please complete the following information. If you have any questions, please ask the receptionist for assistance.

Date ____/____/____
Birthdate ____/____/____ Age _____
Male _____ Female _____
Married _____ Single _____

Name _____ Preferred Name _____
Address _____
City _____ State _____ Zip _____
Home Phone _____ Work Phone _____
Social Security Number _____-____-_____
Occupation _____ Employer _____

How did you hear about this office? _____

When was your last eye exam? _____ Doctor _____
Family Physician _____

Insurance Information

Primary Medical Insurance _____ Member/Employee Date of Birth ____/____/____
Member/Employee Name_____ Member/Employee Work Phone _____
Member/Employee ID#_____ Member/Employee Social Security Number _____-____-_____
Employer/Work Name _____ Group/Policy Number _____

Vision or Secondary Medical Insurance _____ Member/Employee Date of Birth ____/____/____
Member/Employee Name_____ Member/Employee Work Phone _____
Member/Employee ID#_____ Member/Employee Social Security Number _____-____-_____
Employer/Work Name _____ Group/Policy Number _____

I request that payment of authorized insurance benefits be made on my behalf to Dr. Carl Vinson for any services furnished me by this provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

We consider it an honor to serve you. For your convenience we honor all major credit cards, personal checks, and cash. Revolving credit is available upon credit approval. Payment is expected when services are rendered. I understand that in the event my account is not paid according to terms, I will be responsible for, in addition to the balance due, all costs of collection, including collection agency fees, court cos and reasonable attorney's fees.

Signed _____ Date _____

Medical History Questionnaire

Name: _____ Today's Date: ____/____/____

Medical History

Do you have any allergies to medications? ❑ no ❑ yes If yes, explain: _____

_____

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies):

_____

_____

List all major injuries, surgeries and/or hospitalizations you have had: _____

_____

Have you ever had any of the following? (circle)

crossed eyes lazy eye drooping eyelid prominent eyes glaucoma
retinal disease cataracts eye infections eye injury

Explain: _____

_____

Are you pregnant and/or nursing? ❑ no ❑ yes

Do you wear glasses? ❑ no ❑ yes If yes, how old is your present pair of lenses? _____

Do you wear contact lenses? ❑ no ❑ yes If yes, how old is your present pair of lenses? _____

Type of contact lenses: ❑ Rigid ❑ Soft ❑ Extended Wear ❑ Other Are they comfortable? ❑ yes ❑ no

Family History

Please note any family history (parents, grandparents, siblings, children, living or deceased) for the following conditions:

DISEASE	NO	YES	?	RELATIONSHIP TO YOU
Blindness	❑	❑	❑	
Cataract	❑	❑	❑	
Crossed Eyes	❑	❑	❑	
Glaucoma	❑	❑	❑	
Macular Degeneration	❑	❑	❑	
Retinal Detachment/Disease	❑	❑	❑	
Arthritis	❑	❑	❑	
Cancer	❑	❑	❑	
Diabetes	❑	❑	❑	
Heart Disease	❑	❑	❑	
High Blood Pressure	❑	❑	❑	
Kidney Disease	❑	❑	❑	
Lupus	❑	❑	❑	
Thyroid Disease	❑	❑	❑	
Other _____	❑	❑	❑	

☺ *Please turn this form over and complete side two* ☺

Social History

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

❑ *Yes, I would prefer to discuss my Social History directly with my doctor. (Check box)*

Do you drive? ❑ no ❑ yes If yes, do you have visual difficulty when driving? ❑ no ❑ yes If yes, please describe:

_____

Do you use tobacco products? ❑ no ❑ yes If yes, type/amount/how long: _____
Do you drink alcohol? ❑ no ❑ yes If yes, type/amount/how long: _____
Do you use illegal drugs? ❑ no ❑ yes If yes, type/amount/how long: _____
Have you ever been exposed to or infected with: ❑ Gonorrhea ❑ Hepatitis ❑ HIV ❑ Syphilis

Review of Systems

Do you currently, or have you ever had any **persistent** problems in the following areas:

SYSTEM	NO	YES	?
CONSTITUTIONAL			
Fever, Weight Loss/Gain	❑	❑	❑
INTEGUMENTARY (Skin)	❑	❑	❑
NEUROLOGICAL			
Headaches	❑	❑	❑
Migraines	❑	❑	❑
Seizures	❑	❑	❑
EYES			
Loss of Vision	❑	❑	❑
Blurred Vision	❑	❑	❑
Distorted Vision/Halos	❑	❑	❑
Loss of Side Vision	❑	❑	❑
Double Vision	❑	❑	❑
Dryness	❑	❑	❑
Mucous Discharge	❑	❑	❑
Redness	❑	❑	❑
Sandy or Gritty Feeling	❑	❑	❑
Itching	❑	❑	❑
Burning	❑	❑	❑
Foreign Body Sensation	❑	❑	❑
Excess Tearing/Watering	❑	❑	❑
Glare/Light Sensitivity	❑	❑	❑
Eye Pain or Soreness	❑	❑	❑
Chronic Infection of Eye or Lid	❑	❑	❑
Flashes/Floaters in Vision	❑	❑	❑
Tired Eyes	❑	❑	❑
ENDOCRINE			
Thyroid/Other Glands	❑	❑	❑

	NO	YES	?
EARS, NOSE, MOUTH, THROAT			
Allergies/Hay Fever	❑	❑	❑
Sinus Congestion	❑	❑	❑
Runny Nose	❑	❑	❑
Post-Nasal Drip	❑	❑	❑
Chronic Cough	❑	❑	❑
Dry Throat/Mouth	❑	❑	❑
RESPIRATORY			
Asthma	❑	❑	❑
Chronic Bronchitis	❑	❑	❑
Emphysema	❑	❑	❑
VASCULAR / CARDIOVASCULAR			
Diabetes	❑	❑	❑
Heart Pain	❑	❑	❑
High Blood Pressure	❑	❑	❑
Vascular Disease	❑	❑	❑
GASTROINTESTINAL			
Diarrhea	❑	❑	❑
Constipation	❑	❑	❑
GENITOURINARY			
Genitals/Kidney/Bladder	❑	❑	❑
BONES / JOINTS / MUSCLES			
Rheumatoid Arthritis	❑	❑	❑
Muscle Pain	❑	❑	❑
Joint Pain	❑	❑	❑
LYMPHATIC / HEMATOLOGIC			
Anemia	❑	❑	❑
Bleeding Problems	❑	❑	❑
ALLERGIC / IMMUNOLOGIC	❑	❑	❑
PSYCHIATRIC	❑	❑	❑

If you answered YES to any of the above or you have a condition NOT listed, please explain:

_____

_____

_____

_____ _____

Doctor's Signature Date

COVID-19 QUESTIONNAIRE

1. Are you experiencing any of the following symptoms? Please select all that apply.
   - ☐ Fever, chills or sweating
   - ☐ New or worsening cough
   - ☐ Fatigue
   - ☐ Body aches
   - ☐ Diarrhea
   - ☐ Reduced sense of smell and/or taste
   - ☐ Mild to moderate difficulty breathing
   - ☐ Sore throat
   - ☐ Runny nose
   - ☐ None of the above

2. Have you been around someone who is known to have COVID-19 (coronavirus)?
   - ☐ Yes
   - ☐ No

3. Have you been tested before for COVID-19?
   - ☐ Yes, results negative
   - ☐ Yes, results positive – Date of positive test: _____
   - ☐ No

Optional Screening with Ultra Wide Field Photos of the inside of your eyes. ----

An exam of the retina (the inner lining of your eyes) can lead to early detection of common eye diseases, as well as signs of other diseases including hypertension, diabetes, and even brain tumors. Unfortunately, patients may experience some discomfort during the exam which involves dilated pupils and a bright exam light.

Optional screening photos offer several advantages:

(1) Does not require dilation with eye drops.
(2) No need for temporary sunglasses since eyes are not dilated.
(3) Painlessly captures retinal images in just a few seconds.
(4) In most cases, eliminates the need for dilation eye drops.
(5) Produces high resolution photos which your doctor can review with you.
(6) The images become part of your medical record for future comparisons.

Screening photos such as these are not covered by vision or medical insurance.

__ I choose screening digital retina photos - cost $39.00

__ I choose traditional dilated retinal exam with dilation eye drops (usually covered by vision or medical insurance, except for usual deductibles and co-pays)

FOR PATIENT USE

Lifestyle Index

FOR OFFICE USE

PT INITIALS / ID _____

DATE _____

This questionnaire is meant to help your doctor understand what you're experiencing on a regular basis — **whether it's caused by your eyes, posture, stress, etc.** Your responses will help make sure you receive the best care possible.

How often do you experience any of these symptoms? Fill in applicable circle. For example: 1 2 **3** 4 5

Headaches

- You get headaches of any severity each week (even just a dull ache counts).
- Your headaches tend to get worse later in the day.

1 Never ○ | 2 Rarely ○ | 3 Sometimes ○ | 4 Very Often ○ | 5 Always ○

Additional notes: _____

Stiffness / pain in neck / shoulders

You experience stiffness/tension in your neck/shoulders when you work at a computer or read (this might even be from your posture).

1 Never ○ | 2 Rarely ○ | 3 Sometimes ○ | 4 Very Often ○ | 5 Always ○

Additional notes: _____

Discomfort with Computer Use

Your eyes get tired, burn, or get red easily when you work at a computer for long hours.

1 Never ○ | 2 Rarely ○ | 3 Sometimes ○ | 4 Very Often ○ | 5 Always ○

Number of hours per day using a digital device: _____

Tired Eyes

Your eyes feel increasingly fatigued/tired as the day goes on.

1 Never ○ | 2 Rarely ○ | 3 Sometimes ○ | 4 Very Often ○ | 5 Always ○

Additional notes: _____

Dry Eye Sensation

Your eyes progressively feel more dry/sandy/gritty while working at the computer or reading.

1 Never ○ | 2 Rarely ○ | 3 Sometimes ○ | 4 Very Often ○ | 5 Always ○

Additional notes: _____

Light Sensitivity

Bright / Strong lights (vehicle headlights, florescent lights etc.) bother you.

1 Never ○ | 2 Rarely ○ | 3 Sometimes ○ | 4 Very Often ○ | 5 Always ○

Additional notes: _____

Dizziness

You experience dizziness, motion sickness, or vertigo.

1 Never ○ | 2 Rarely ○ | 3 Sometimes ○ | 4 Very Often ○ | 5 Always ○

Additional notes: _____

Additional Notes

Any additional notes you'd like to add: _____

Dr. CARL VINSON
OPTOMETRIST

Consent to Examine, Diagnose, and Initiate Treatment

I, _____, do hereby consent to treatment for myself. I give permission for the doctor(s) to examine, diagnose, and initiate treatment as deemed appropriate.

_____ _____
(Patient Signature) (Date)

Master

Dr. CARL VINSON
OPTOMETRIST

PATIENT CONSENT/ACKNOWLEDGEMENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. This includes, but is not limited to, disclosure to third party medical care providers to whom we refer you or with whom we consult regarding your health, as well as to third parties for payment or billing purposes. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- Dr. Carl Vinson has a Notice of Privacy Practices and that the patient has the opportunity to review this notice.
- Dr. Carl Vinson reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information but Dr. Carl Vinson does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- Dr. Carl Vinson may condition treatment upon the execution of this Consent.

I request that a copy of the "Notice Of Privacy Practices" ___be given / ___not be given to me

_____	_____	_____
Signature	Printed Name – Patient or Representative	Date

_____ In front of: _____

Relationship to patient (if other than patient)