Personal Information

Last Name	First Name	MI	D.O.B.	Home Phone/Cell Phone
Street Address	City	State	Zip	
Occupation	Email Address		List vision related hobbies above	

Health History

Do you currently have or have had any of the following conditions?

- ☐ High Cholesterol
- ☐ Thyroid Problems
- ☐ Anxiety/Depression
- ☐ Immune Disorders
- ☐ Hepatitis
- ☐ Other________________
- ☐ Respiratory Problems
- ☐ Stroke/Neurological
- ☐ Cardiovascular Problems
- ☐ Blood Clot/Bleeding
- ☐ Sickle Cell/Anemia
- ☐ Tuberculosis
- ☐ Cancer
- ☐ Kidney problems
- ☐ Skin Disorders
- ☐ Arthritis
- ☐ HIV/AIDS
- ☐ Pregnant or Nursing

Do you or any of your immediate family members have any of these conditions?

Self	Relative	None	Condition
❍	☐	◇	Diabetes
❍	☐	◇	Hypertension
❍	☐	◇	Eye Infection
❍	☐	◇	Blindness
❍	☐	◇	Cataracts
❍	☐	◇	Glaucoma
❍	☐	◇	Macular Degeneration
❍	☐	◇	Retinal Problems
❍	☐	◇	Amblyopia/Lazy Eye
❍	☐	◇	Strabismus/Crossed Eyes
❍	☐	◇	Eye Trauma
❍	☐	◇	Eye Surgery

Do you smoke cigarettes? Y N

Do you participate in recreational drugs? Y N

Do you drink alcohol? Y N

MEDICATIONS (ALL ORAL, INHALATION, AND EYEDROPS)			**MEDICATION ALLERGY**

MS Vision Care Condition of Registration and Financial Policy

The following are conditions of registration as well as our policies with respect to the billing and collections of your account: Payment is due in full at the time service is provided in the office. You are responsible for all co-insurance, co-pays, and deductible not covered by your insurance. For patients with vision/commercial insurance, all co-pays are due at the time of service. We will bill insurance on your behalf only if we have a current contract with the carrier. It will be your responsibility to submit a claim to insurances to which we do not participate with the proper documentation. If an insurance claim goes unpaid for sixty (60) days you will be responsible for the full amount. Any care not paid for by your insurance coverage will require payment in full. There will be a fee of $25.00 charged by this office for all returned checks.

Records Release, HIPPA Privacy Authorization & Assignment of Insurance Benefits

I hereby authorize MS Vision Care, LLC to have access to my clinical records from Target Optical and previous subleasing doctors, and acknowledge that MS Vision Care's notice of privacy practices were offered, received, and understood. I hereby assign all vision and medical benefits, to include major medical benefits to which I am entitled, private insurance and any other vision and/or health plans to MS Vision Care, LLC. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not the charges are paid by said insurance. I hereby authorize said assignee to release all information necessary to adjudicate all claims and secure payment for the services rendered.

X ____

Please Sign and Date Above (Guardian must sign if under 18 years old)