WELCOME TO GUTHRIE VISION SOURCE

GENERAL INFORMATION

NAME	BIRTHDATE	CELL PHONE	ALTERNATE PHONE

MAILING ADDRESS	CITY, STATE, ZIP	SSN (OVER 17)

EMAIL ADDRESS	MALE ☐ FEMALE ☐	RACE	HISPANIC ☐ NOT HISPANIC ☐	LANGUAGE

OCCUPATION / EMPLOYER NAME	EMERGENCY CONTACT NAME AND NUMBER
FULL TIME☐ PART TIME☐	

INSURANCE INFORMATION

VISION INSURANCE	PRIMARY MEMBER FULL NAME	BIRTHDATE	SSN
PRIMARY MEDICAL INSURANCE	**PRIMARY MEMBER FULL NAME**	**BIRTHDATE**	**SSN**
SECONDARY MEDICAL INSURANCE	**PRIMARY MEMBER FULL NAME**	**BIRTHDATE**	**SSN**

MEDICAL HISTORY

DO YOU WEAR GLASSES _____ CONTACTS _____		GLAUCOMA	SELF ☐ FAMILY ☐
DO YOU OR YOUR FAMILY HAVE ANY OF THE FOLLOWING: PLEASE LEAVE BLANK IF NOT		LASIK OR RK	SELF ☐ FAMILY ☐
		LAZY EYE	SELF ☐ FAMILY ☐
ALLERGIES	SELF ☐ FAMILY ☐	MACULAR DEGENERATION	SELF ☐ FAMILY ☐
ASTHMA / RESPIRATORY ISSUES	SELF ☐ FAMILY ☐	RETINAL DETACHMENT	SELF ☐ FAMILY ☐
BLOOD / LYMPH DISORDER	SELF ☐ FAMILY ☐	OTHER:	
CANCER	SELF ☐ FAMILY ☐		
DIABETES / ENDOCRINE	SELF ☐ FAMILY ☐	CURRENT MEDICATIONS:	
HEART DISEASE / CARDIOVASCULAR	SELF ☐ FAMILY ☐		
LUPUS / IMMUNE DYSFUNCTION	SELF ☐ FAMILY ☐		
MUSCULOSKELETAL	SELF ☐ FAMILY ☐	MEDICATION DRUG ALLERGIES:	
NEUROLOGICAL CONDITIONS	SELF ☐ FAMILY ☐		
PSYCHIATRIC DISORDER	SELF ☐ FAMILY ☐		
SEIZURES	SELF ☐ FAMILY ☐	ARE YOU PREGNANT OR NURSING	YES ☐ NO☐
SKIN DISORDERS	SELF ☐ FAMILY ☐	DO YOU SMOKE?	YES ☐ NO☐
STROKE	SELF ☐ FAMILY ☐	DO YOU USE ILLICIT DRUGS?	YES ☐ NO☐

- I understand that there is a 24-hour appointment cancellation policy and that I may have to pay a $25.00 fee for late cancellations or no-showed appointments.

- Our office may use standard email to communicate with you. Standard email is not secure and does not guarantee privacy. (check one)

___ I authorize the use of standard email, despite the known risk involved, to communicate with me.

___ I do not authorize the use of standard email to communicate with me.

Acknowledgment of Notice of Privacy Practices

Guthrie Vision Source PC, Inc.
110 E. Harrison Ave Guthrie OK 73044

The law requires that Guthrie Vision Source PC, Inc. make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

____(initial) *I was given the opportunity to read, have read or had explained to me Guthrie Vision Source PC, Inc.'s Notice of Privacy Practice prior to any services offered. OR The Notice of Privacy Practice could not be read due to the emergent nature of the care and will be acquired when possible.*

I authorize Guthrie Vision Source PC, Inc. to release my personal health information to the following individuals:

_____ _____

_____ _____

Acknowledgement of Insurance Benefit Filing

Many patients have both vision and medical insurance. These plans cover different types of services, and it is important to us that our patients understand those differences.

Vision plans cover routine vision care which will determine a prescription for glasses/contacts. **Medical** plans are designed to handle non-routine medical conditions (i.e., diabetes, cataracts, ocular injuries, or infections, etc.). If a medical diagnosis or condition is present, we will file the visit with your medical plan. Co-pays and deductibles (as defined by your insurance plan) will apply, as will any non-covered service or out-of-network charges.

___ (initial) I understand that I am responsible for providing my vision insurance information as well as my medical insurance cards prior to my visit with the doctor.

___ (initial) I understand that *Guthrie Vision Source PC*, Inc. will be submitting claims for my visit to the appropriate insurance plan based on my condition, diagnosis and/or treatment plan.

___ (initial) I understand that if I do not provide the insurance information as requested, I will be responsible for payment at check-out for the total amount of charges. I will also be responsible for filing my own insurance claim for reimbursement if so desired.

I HAVE READ AND UNDERSTAND THIS FORM IN ITS ENTIRETY. I AM SIGNING IT VOLUNTARILY.

_____ _____ _____

Patient/Representative Signature Relationship to patient Date

If you are signing as a personal representative of the patient, please indicate your relationship. If you are signing for a minor, you attest that you have legal authority to make medical decisions for the minor.