WELCOME TO GUTHRIE VISION SOURCE

HOW DO YOU PLAN TO PAY TODAY? CASH ☐ CREDIT ☐ CHECK ☐ CARE CREDIT ☐

IF YOU DO NOT HAVE SUFFICIENT FUNDS, PLEASE SPEAK WITH RECEPTION ABOUT RESCHEDULING

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 FULL TIME☐ PART TIME☐	EMERGENCY CONTACT NAME AND NUMBER

INSURANCE INFORMATION

VISION INSURANCE	PRIMARY MEMBER FULL NAME	PRIMARY MEMBER BIRTHDATE	PRIMARY MEMBER SSN
PRIMARY MEDICAL INSURANCE	IS PRIMARY MEMBER SAME AS ABOVE: YES ☐ NO ☐ IF NO: NAME__________________ BIRTHDATE __________ SSN ____________ RELATIONSHIP TO PRIMARY ____________		
SECONDARY MEDICAL INSURANCE	IS PRIMARY MEMBER SAME AS ABOVE: YES ☐ NO ☐ IF NO: NAME__________________ BIRTHDATE __________ SSN ____________ RELATIONSHIP TO PRIMARY ____________		

MEDICAL HISTORY

DO YOU WEAR GLASSES ________ CONTACTS _______		SKIN CONDITION	SELF ☐ FAMILY ☐
DO YOU OR YOUR FAMILY HAVE ANY OF THE FOLLOWING: PLEASE LEAVE BLANK IF NOT		STROKE	SELF ☐ FAMILY ☐
AIDS / HIV	SELF ☐ FAMILY ☐	THRYOID DISFUNCTION	SELF ☐ FAMILY ☐
ALLERGIES	SELF ☐ FAMILY ☐	CATARACTS	SELF ☐ FAMILY ☐
ARTHRITIS	SELF ☐ FAMILY ☐	CROSSED EYE	SELF ☐ FAMILY ☐
ASTHMA	SELF ☐ FAMILY ☐	GLAUCOMA	SELF ☐ FAMILY ☐
BLOOD / LYMPH DISORDER	SELF ☐ FAMILY ☐	LASIK OR RK	SELF ☐ FAMILY ☐
CANCER	SELF ☐ FAMILY ☐	LAZY EYE	SELF ☐ FAMILY ☐
DIABETES	SELF ☐ FAMILY ☐	MACULAR DEGENERATION	SELF ☐ FAMILY ☐
EARS, NOSE, THROAT CONDITION	SELF ☐ FAMILY ☐	RETINAL DETACHMENT	SELF ☐ FAMILY ☐
GASTROINTESTINAL CONDITION	SELF ☐ FAMILY ☐	CURRENT MEDICATIONS	
HEART DISEASE	SELF ☐ FAMILY ☐		
HIGH BLOOD PRESSURE	SELF ☐ FAMILY ☐		
KIDNEY DISEASE	SELF ☐ FAMILY ☐	MEDICATION DRUG ALLERGIES	
LUPUS	SELF ☐ FAMILY ☐		
NEUROLOGICAL CONDITIONS	SELF ☐ FAMILY ☐		
PSYCHIATRIC DISORDER	SELF ☐ FAMILY ☐	ARE YOU PREGNANT OR NURSING	YES ☐ NO☐
SEIZURES	SELF ☐ FAMILY ☐	DO YOU SMOKE?	YES ☐ NO☐

Acknowledgment of Notice of Privacy Practices

Guthrie Vision Source PC, Inc.
110 E. Harrison Ave Guthrie OK 73044
405-282-4396

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:

________________________________ ____________________________

________________________________ ____________________________

My vision plan requests that all diagnoses related to any medical condition I may have be released to them. As a non-traditional disclosure, release of this information requires my specific authorization: (check one)
___ I authorize the release of medical information to my vision plan
___ I do not authorize release of medical information to my vision plan

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, in spite of the known risk involved, to communicate with me.
___ I do not authorize the use of standard email to communicate with me.

-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.
-I understand that payment for services and materials is required at the time of service. If I do not pay the entire new balance within 30 days, late fee penalties may be added to the balance and the patient or legal guardian will be responsible for the balance due.

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

____ ______________________
Patient Signature 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.

____ ______________________________
Representative Signature Relationship to Patient