

WELCOME TO GUTHRIE VISION SOURCE

GENERAL INFORMATION

NAME	BIRTHDATE	CELL PHONE	ALTERNATE PHONE
MAILING ADDRESS	CITY, STATE, ZIP		SSN (OVER 17)
EMAIL ADDRESS	MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>	RACE HISPANIC <input type="checkbox"/> NOT HISPANIC <input type="checkbox"/>	LANGUAGE
OCCUPATION / EMPLOYER NAME		EMERGENCY CONTACT NAME AND NUMBER	

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

-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.

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

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:

VISION INSURANCE vs MEDICAL INSURANCE

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, ocular pathology, diagnoses and/or treatment plans for those conditions.

When a medical diagnosis or condition is present (i.e., diabetes, cataracts, or dry eye diagnosis, etc.) 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 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.*

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.

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.