708 Hill Country Dr., Suite 100
830-257-5656 www.https://visionsource-kerrville.com

Last Name: ____________________ **First Name:** ________________ **MI:** ____ **Nickname:** ____________ Male / Female

Mailing Address: ______________________________________ **City:** ____________________ **State:** _____ **Zip:** ________

Primary Phone: _________________________ **Cell Phone:** ___________________________ **Is texting okay?** Yes / No

Email: ____ **Date of Birth:** ____________ **SS#:** ___________________

Employer: ________________________________ **Occupation:** __________________________ **Status:** Married / Single

Communication Preference: Email / Text / Phone / Mail **Preferred Language:** __________________

Ethnicity: Caucasian / Hispanic or Latino / Other **How did you hear about us?** ________________________________

Primary Care Physician: ___________________________________

Fill out the following if you have insurance and are NOT the policy holder

Policy Holder's Full Name: _______________________________________**SS#:** ___________________ **DOB:** ___________

RESPONSIBLE PARTY
(If patient is under 18)

Full Name: ____ **DOB:** ______________

SS#: ________________________________ **Relationship to Patient:** ______________________

ACKNOWLEDGEMENTS

Payment Policy-
Examination fee is due at time of service as well as known co-pays and fees for non-covered services, tests, and materials. It is the patient's responsibility to provide our office with accurate information for billing medical/vision plans at the time of service. It is also the patient's responsibility to know what the insurance plan covers as well as if a PCP referral is required before treatment. If the insurance company has not paid a claim in full within 30 days of filing, the patient will receive a bill from our office that will be due within 30 days of receipt. Any account not paid by the due date may be sent to an outside collection agency and all legal/service fees/charges incurred will be the responsibility of the patient. Return/NSF checks will be charged a $30 Service Fee. All sales are final and no refunds will be given for professional fees, glasses or contact lenses.

Consent to Treat-
I hereby authorize Vision Source, it's doctors and employees, to provide optometric treatment to my child or me, including but not limited to: examinations, diagnostic tests, fitting of contact lenses and other medical procedures which may be deemed necessary in the course of my care. I further authorize the release of Protected Health Information to additional physicians or optometrists in order to facilitate continuity of care.

****Eyeglass Prescription Policy****
I understand that my eyeglass prescription will be made available electronically immediately upon completion of a refractive eye examination through my patient portal. In addition, I may request a printed copy of my eyeglass prescription at any time and it will be provided by Vision Source.

I have read and understand all the above information and am signing this form voluntarily.

X____

Signature of patient or Guarantor **Relationship *(if not patient)*** **Date**

** * * * * * * * * THIS SECTION FOR OFFICE USE ONLY * * * * * * * * **

Dr. TILLEY Dr. WHITEHEAD

PP NP CL Patient ID_________________ Last Exam__________________

Do You Wear *or* Have You Worn:

(Please check-mark ALL that apply)

- ❏ Eyeglasses
- ❏ Computer Glasses
- ❏ Sunglasses
- ❏ Contacts

Are you interested in Contacts? Yes / No **Are you interested in LASIK?** Yes / No

MEDICAL HISTORY

(Please check-mark ALL that apply AND list the approximate DATE of diagnosis)

- ❏ Anxiety- DATE:__________
- ❏ Arthritis- DATE:__________
- ❏ Asthma- DATE:__________
- ❏ Atrial Fibrillation- DATE::_________
- ❏ Cancer- DATE:________ TYPE:______
- ❏ COPD- DATE:_________
- ❏ Coronary Artery Dis.- DATE:_______
- ❏ Depression- DATE:_________
- ❏ Diabetes
  - ❏ DATE:_____ TYPE:___ A1C:____ FBS: ____
- ❏ High Blood Pressure- DATE:_______
- ❏ Hearing Loss- DATE:_________
- ❏ Hepatitis- DATE:_________TYPE:______
- ❏ HIV/AIDS- DATE:_________
- ❏ High Cholesterol- DATE:_________
- ❏ Thyroid Disease- DATE:_________
- ❏ Seizures- DATE:_________
- ❏ Stroke- DATE:_________
- ❏ Pregnant- DUE DATE:_________
- ❏ OTHER: ______________________
- ❏ OTHER: ______________________

OCULAR SURGICAL HISTORY

(Ocular procedures and DATES)

______________________________________ ______________________________________ ______________________________________
______________________________________ ______________________________________ ______________________________________
______________________________________ ______________________________________ ______________________________________

OCULAR HISTORY

(Please check-mark ALL that apply AND list the DATE of diagnosis)

- ❏ Cataracts- DATE:____________
- ❏ Diabetic Retinopathy- DATE:_______
- ❏ Dry Eyes- DATE:____________
- ❏ Glaucoma- DATE:____________
- ❏ Macular Degeneration. -DATE:_______
- ❏ Retinal Tear- DATE:____________
- ❏ Strabismus/Lazy Eye- DATE:_______
- ❏ Floaters- DATE:____________
- ❏ OTHER:_______________________

MEDICATIONS

(List ALL medications AND dosages, including OTC vitamins and eye drops)

______________________________________ ______________________________________ ______________________________________
______________________________________ ______________________________________ ______________________________________
______________________________________ ______________________________________ ______________________________________

ALLERGIES

(List *ALL* medication and non-medication allergies AND their reaction)

______________________________________ ______________________________________ ______________________________________
______________________________________ ______________________________________ ______________________________________

SOCIAL HISTORY

- ❏ Never Smoker
- ❏ Current Smoker
- ❏ Former Smoker
- ❏ Smokeless Tobacco

FAMILY HISTORY

(Please check-mark all that apply AND list relationship to you: e.g. Mom, Dad, Sister, Brother, etc...)

- ❏ Glaucoma: ____
- ❏ Macular Degeneration: ______________________________
- ❏ Diabetes: ____

CURRENT EYE SYMPTOMS

(check-mark all circles that apply)

- ❏ Blurry Vision
- ❏ Light Sensitivity
- ❏ Irritation
- ❏ Burning
- ❏ Discharge
- ❏ Dryness
- ❏ Pain
- ❏ Tearing/Watering
- ❏ Redness
- ❏ Headache
- ❏ Other:_____________
- ❏ Other:_____________