Welcome to Lorain Family Vision

PLEASE COMPLETE BOTH SIDES

(Please Print)

Name ______________________________ How long has it been since your last eye exam? _______year (s)

Street ______________________________ **Date of Birth** ____________________ **Sex M or F**

City ________________________**State** _______ **Zip** ________**Last 4 SSN** ________________________

Cell OR Home Phone ____________________________ **Text OK? YES NO**

Email Address ____

Employer or School ____________________________ **Occupation** ________________________________

How did you hear about us? _________________**What is your main reason for your visit today?** ____________________

Do you work/view a computer/phone/tablet more than 4 hours per day? YES NO

Do you have neck/muscle aches at the computer? YES NO

Do you currently have prescription sunglasses? YES NO Computer Glasses? YES NO Work/Safety Glasses? YES NO

Do you have a current Medical Doctor (MD)? YES NO Name ____

Do YOU have any of the Following: PLACE AN 'X' IF YES FOR SELF OR RELATIVE

	Self	Relative		Self	Relative		Self	Relative		Self	Relative
Diabetes			Cancer history			High Blood Pressure			Heart Disease		
Arthritis			Thyroid Disease			Glaucoma			Double Vision		
Macular Degeneration			Cataracts			Lazy Eye/Amblyopia			Headaches		

Are You Taking any Prescription Medications? YES NO You DO NOT need to list medications

Do you smoke cigarettes/tobacco? YES NO **Do you drink alcohol? YES NO**

Please list any Allergies: ____

Dilation of Pupils

Dr. Alton strongly recommends that your pupils are dilated to thoroughly evaluate the health of the inside of your eye. Being a new patient we recommend your eyes be dilated at the first visit and then every two years following. The drops may cause it to be bright outdoors, you can usually drive and they may affect your focusing at near for 3-4 hours**.**

If you want to be dilated at a later date please initial here _____

Financial Responsibility

All charges and co-pays incurred today are the responsibility of the patient or parent at the time of service. **We accept personal checks, cash, debit, credit and care credit for payment. If your insurance company has not paid us within 30 days, you will be sent a bill for the unpaid amount.** Your insurance company is providing a service for you and it is not the responsibility of this office to secure payment from them. This is also your **"signature on file"** for us to receive insurance reimbursement payment.

ALL GLASSES AND CONTACT LENSES MUST BE PAID IN FULL BEFORE ORDERING.

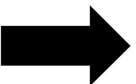
NO MATERIALS OR PRESCRIPTIONS WILL BE RELEASED UNLESS PAID IN FULL

NO REFUNDS FOR SERVICES OR MATERIALS

Dr Alton and his staff are committed to solving any issues.

I understand and accept financial responsibility for any charges incurred: ____________________________ **Date**_______

All information on this sheet is personal and confidential including your email and will not be shared with anyone else unless you give your permission. All HIPPA rules and regulations apply.



ACKNOWLEDGEMENT OF NOTIFICATION OF PATIENT'S RIGHT TO PRIVACY

I acknowledge that I have been notified by Dr. Paul J. Alton/Lorain Family Vision Notification of Patient's Right to Privacy

Patient Name____

Signature____Date__________

To allow Dr. Paul J. Alton/Lorain Family Vision to discuss your medical condition, treatment plan, surgery plan, appointment dates and times etc. with a family member or other person involved in your health care, please list their names and relationships to you below. You are not required to list anyone if you chose not to.

I authorized Dr. Paul J. Alton/Lorain Family Vision to release health information identifying me to the family member or other persons I have listed below:

Name____________________________Relationship__________________

Name____________________________Relationship__________________