



**PATIENT INFORMATION**

Name (Last, First, M) \_\_\_\_\_

E-Mail \_\_\_\_\_ Birthdate \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age \_\_\_\_

**WHAT IS THE REASON FOR YOUR VISIT TODAY?** \_\_\_\_\_

\_\_\_\_\_ **DO YOU WANT NEW GLASSES?** \_\_\_\_\_

Telephone \_\_\_\_\_ If Referred: TV  Radio  Newspaper  Physician  Other

Have there been any changes to the health of you or your family since your last eye examination? (explain)

\_\_\_\_\_

**PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT (Must be age 18 or older)**

Name (Last, First, M) \_\_\_\_\_ E-Mail \_\_\_\_\_

Address \_\_\_\_\_ Years There \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_ Telephone (R) \_\_\_\_\_ (W) \_\_\_\_\_

Social Security Number \_\_\_\_\_ Driver Lic. No \_\_\_\_\_ Patient SS# \_\_\_\_\_

Previous Address (if current <6mo) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ zip \_\_\_\_\_

Patient or Parent Employer \_\_\_\_\_ Years There \_\_\_\_\_ Telephone \_\_\_\_\_

Position \_\_\_\_\_ Employers Address \_\_\_\_\_

Spouse Name \_\_\_\_\_ Spouse Employment \_\_\_\_\_

Payment Method (circle) Cash Check Credit Card

**Credit Policy**

I understand that all services and materials charges incurred are my responsibility and all co-payments and insurance overages are due at the time of service. A FINANCE CHARGE of 1% will be incurred monthly on all accounts with a balance. I may pay the total balance due at any time without penalty or additional FINANCE CHARGES. I am responsible for the cost of COLLECTION and reasonable attorney fees.

I have read and understand the credit policy listed above.

**Signed** \_\_\_\_\_ **Date** \_\_\_\_\_

**YOUR INSURANCE INFORMATION**

**Name of Insurance Company** \_\_\_\_\_ Telephone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ zip \_\_\_\_\_

Name of Insured \_\_\_\_\_ Relationship to Insured \_\_\_\_\_

Insured Telephone Number \_\_\_\_\_ Insured Group Name \_\_\_\_\_

Insured Social Security # \_\_\_\_\_ Patient SS# \_\_\_\_\_ Group/Policy Number \_\_\_\_\_

**Secondary Insurance Company** \_\_\_\_\_ Telephone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insured Telephone Number \_\_\_\_\_ Insured Group Name \_\_\_\_\_

Insured Social Security # \_\_\_\_\_ Patient SS# \_\_\_\_\_ Group/Policy Number \_\_\_\_\_

**CLEAR VIEW EYE CLINIC, INC INSURANCE AND PAYMENT POLICY**

As a courtesy to you , our clinic will submit claims to your insurance company for you. However, we cannot accept liability for collecting your claim because the policy is a contract between you and your insurance company.

I agree to furnish the appropriate insurance information to the Clear View Eye Clinic, Inc so that they may submit charges to my insurance company. If I do not have this information I understand that I am responsible for the charges in full on the date of service.

I hereby authorize benefits, which I am entitled, to be paid to Clear View Eye Clinic, Inc. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges incurred including services not paid by my insurance if I have insurance. Any portion of the claim not covered within 30 days will be my responsibility. I understand that after 30days Clear View Eye Clinic, Inc will continue to help collect my benefits from my insurance company.

*INSURANCE REQUIRES THAT CO-PAYMENTS AND OVERAGES ARE DUE AT THE TIME OF SERVICE*

I have read and understand the above insurance policy. I also hereby authorize Clear View Eye Clinic, Inc to release any information acquired in the course of my care for insurance purposes.

Signed \_\_\_\_\_ Date \_\_\_\_\_

**ADVANCED BENEFICIARY NOTICE & INFORMED CONSENT**

I understand that my doctor may find it reasonable and necessary to perform additional tests or treatments. I will be informed of their risks, benefits and options. I know that no insurance company covers all services and materials. I am responsible for all services and material charges disclosed to me, \_\_\_\_\_ even those considered non-covered by my insurance.

Signed \_\_\_\_\_ Date \_\_\_\_\_



**CLEAR VIEW  
EYE CLINIC**  
**MEDICAL HISTORY QUESTIONNAIRE**

Name (Last, First, M) \_\_\_\_\_ Today's Date \_\_\_\_\_

**ARE YOU INTERESTED IN ANY OF THE FOLLOWING:**  CONTACT LENSES  GLASSES  
 LASER (LASIK) SURGERY  DRY EYE TREATMENT  OTHER \_\_\_\_\_

Do you wear glasses (how old are they) \_\_\_\_\_ Do you wear contact lenses (how old are they) \_\_\_\_\_  
 Type of Contact Lens \_\_\_\_\_ Are they comfortable \_\_\_\_\_ Type of Solution \_\_\_\_\_

Do you participate in:  Shooting  Skiing  Running  Golf  Tennis  Biking  Other \_\_\_\_\_

Date of Last Eye Exam \_\_\_\_\_ Previous Eye Doctor \_\_\_\_\_ Pharmacy of Choice \_\_\_\_\_

Date of Last Medical (physical) Exam \_\_\_\_\_ Medical Doctor \_\_\_\_\_

List all **major injuries**, surgeries (including eye), and/or **hospitalizations** (including general anesthesia) you've had: \_\_\_\_\_

**LIST ANY MEDICATION(S)** you take (including oral contraceptives, aspirin, OTC medications, supplements and home remedies): \_\_\_\_\_

**MEDICATION ALLERGIES** \_\_\_\_\_

Are you pregnant or nursing? \_\_\_\_\_ Have you recently had a baby? (delivery date): \_\_\_\_\_

**Family History** (parents, grandparents, siblings, children; living or deceased) for the following:

<u>Disease/Condition</u>	<input type="checkbox"/>	<u>Relationship to you</u>
Blindness	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	_____
Crossed Eyes/Lazy Eye	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	_____
Retinal Detachment	<input type="checkbox"/>	_____
Retinal Disease	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	_____
Lupus	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	_____

**Social History** (can be discussed directly and confidentially with your Doctor during the examination)

Do you use tobacco products, drink alcohol, or use illegal drugs? (explain) \_\_\_\_\_

Have you ever been exposed to or infected with gonorrhea, hepatitis, HIV, or syphilis? \_\_\_\_\_

Do you drive? \_\_\_\_\_ Do you have trouble seeing when driving, especially at night? \_\_\_\_\_

Do you have trouble seeing to read, watch television, walk or perform other daily activities? \_\_\_\_\_

## REVIEW OF SYSTEMS


Have you ever had problems with any of the following areas of your body?:  
(Check Those That Apply and Leave Those That Do Not Apply Blank)

<p><b>SYSTEMIC</b></p> <p><b>ALLERGY/IMMUNE (20% U.S.)</b> <input type="checkbox"/></p> <p><b>CARDIOVASCULAR</b> <input type="checkbox"/></p> <p style="padding-left: 20px;">Heart Disease/Pain <input type="checkbox"/></p> <p style="padding-left: 20px;">High Blood Pressure (33% U.S.) <input type="checkbox"/></p> <p style="padding-left: 20px;">Stroke (3<sup>rd</sup> leading cause of death) <input type="checkbox"/></p> <p style="padding-left: 20px;">Vascular Disease <input type="checkbox"/></p> <p><b>CONSTITUTIONAL</b> <input type="checkbox"/></p> <p style="padding-left: 20px;">Fever, Weight Loss/Gain <input type="checkbox"/></p> <p><b>EARS, NOSE, MOUTH, THROAT</b> <input type="checkbox"/></p> <p style="padding-left: 20px;">Allergies/Hayfever (20% U.S.) <input type="checkbox"/></p> <p style="padding-left: 20px;">Sinus Congestion <input type="checkbox"/></p> <p style="padding-left: 20px;">Runny Nose/Post-Nasal Drip <input type="checkbox"/></p> <p style="padding-left: 20px;">Chronic Cough <input type="checkbox"/></p> <p style="padding-left: 20px;">Dry Throat/Mouth <input type="checkbox"/></p> <p style="padding-left: 20px;">Chronic Throat Infections <input type="checkbox"/></p> <p><b>ENDOCRINE</b> <input type="checkbox"/></p> <p style="padding-left: 20px;">Thyroid/Other Glands (10% U.S.) <input type="checkbox"/></p> <p style="padding-left: 20px;">Hormone Replacement Therapy <input type="checkbox"/></p> <p style="padding-left: 20px;">Diabetes (21 million Americans) <input type="checkbox"/></p> <p><b>GASTROINTESTINAL</b> <input type="checkbox"/></p> <p style="padding-left: 20px;">Diarrhea <input type="checkbox"/></p> <p style="padding-left: 20px;">Constipation <input type="checkbox"/></p> <p><b>GENITOURINARY</b> <input type="checkbox"/></p> <p style="padding-left: 20px;">Genitals/Kidney/Bladder <input type="checkbox"/></p> <p><b>HEMATOLOGIC/LYMPH</b> <input type="checkbox"/></p> <p style="padding-left: 20px;">Anemia <input type="checkbox"/></p> <p style="padding-left: 20px;">Bleeding Disorders <input type="checkbox"/></p> <p><b>INTEGUMENTARY (SKIN)</b> <input type="checkbox"/></p> <p><b>MUSCLE/JOINT/BONES</b> <input type="checkbox"/></p> <p style="padding-left: 20px;">Arthritis (20 million Americans) <input type="checkbox"/></p> <p style="padding-left: 20px;">Muscle /Joint Pain <input type="checkbox"/></p> <p><b>RESPIRATORY</b> <input type="checkbox"/></p> <p style="padding-left: 20px;">Asthma (15 Million Americans) <input type="checkbox"/></p> <p style="padding-left: 20px;">Chronic Bronchitis <input type="checkbox"/></p> <p style="padding-left: 20px;">Emphysema (90% are smokers) <input type="checkbox"/></p> <p><b>NEUROLOGICAL</b> <input type="checkbox"/></p> <p style="padding-left: 20px;">Headaches/Migraines (20% U.S.) <input type="checkbox"/></p> <p style="padding-left: 20px;">MS (1/2million Americans) <input type="checkbox"/></p> <p style="padding-left: 20px;">Head Trauma <input type="checkbox"/></p> <p style="padding-left: 20px;">Seizures <input type="checkbox"/></p> <p><b>PSYCHIATRIC (20% U.S. adults)</b> <input type="checkbox"/></p> <p><b>OTHER</b> <input type="checkbox"/></p>	<p><b>EYES</b> <input type="checkbox"/></p> <p style="padding-left: 20px;">Seeing at Night <input type="checkbox"/></p> <p style="padding-left: 20px;">Loss of Vision/Side Vision <input type="checkbox"/></p> <p style="padding-left: 20px;">Blurred Vision/Distortion <input type="checkbox"/></p> <p style="padding-left: 20px;">Halos/Distorted Vision <input type="checkbox"/></p> <p style="padding-left: 20px;">Computer Use (how much) <input type="checkbox"/></p> <p style="padding-left: 20px;">Double Vision <input type="checkbox"/></p> <p style="padding-left: 20px;">Flashes/Spots <input type="checkbox"/></p> <p style="padding-left: 20px;">Lazy Eye (3% of children) <input type="checkbox"/></p> <p style="padding-left: 20px;">Dryness (10 million Americans) <input type="checkbox"/></p> <p style="padding-left: 20px;">Eye Injury <input type="checkbox"/></p> <p style="padding-left: 20px;">Redness <input type="checkbox"/></p> <p style="padding-left: 20px;">Sandy/Gritty Feeling <input type="checkbox"/></p> <p style="padding-left: 20px;">Itching <input type="checkbox"/></p> <p style="padding-left: 20px;">Burning <input type="checkbox"/></p> <p style="padding-left: 20px;">Foreign Body Feeling <input type="checkbox"/></p> <p style="padding-left: 20px;">Glare/Light Sensitive <input type="checkbox"/></p> <p style="padding-left: 20px;">Eye Pain/Soreness <input type="checkbox"/></p> <p style="padding-left: 20px;">Chronic Eye/lid Infections <input type="checkbox"/></p> <p style="padding-left: 20px;">Sties or Chalazion <input type="checkbox"/></p> <p style="padding-left: 20px;">Tired Eyes <input type="checkbox"/></p> <p style="padding-left: 20px;">Mucus Discharge <input type="checkbox"/></p> <p>If you answered YES to any of the above or have a condition not listed, please explain and list any medications related to that condition: _____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
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\_\_\_\_\_  
Doctor Signature

\_\_\_\_\_  
Date

**WELCOME TO THE CLINIC AND THANK YOU FOR CHOOSING US FOR YOUR EYECARE**


**CLEAR VIEW  
EYE CLINIC**  
 595 S. Illinois Ave.  
 Mason City, IA 50401