VISION SOURCE®

WELCOME TO OUR OFFICE

Crystal Clear Eye Care

190 N. New Rd, Waco, TX 76710
(254)399-9979 Fax (254)399-9608

Today's Date _____

Patient Information

Last _____

First _____ MI _____

Address _____

City _____ State _____

Zip Code _____

Day Phone _____

Cell Phone _____

Patient's SSN _____

Employer (or School) _____

Occupation (or Grade) _____

Date of Birth _____ Age _____

If Minor, Party Responsible _____

Work Phone _____

Driver's License _____

Spouse (or Parent's) Work _____

Patient Sex M F

Email Address _____

Approved Communication: (Circle all that apply)

Text Email Postal Phone

What is the major purpose of this visit? _____

_____

Any problems with your current contact lenses or glasses?

_____

The mission of Crystal Clear Eye Care is to provide the most comprehensive vision care available to every patient, focusing on their unique individual needs. We will provide patients with our very best judgment, helping them understand and achieve the best vision possible and the fullest quality of life. We will continue to encourage a high level of commitment to the patient by constantly educating ourselves on all aspects of vision care.

Insurance Information

Please note that most vision plans DO NOT cover the Contact Lens Evaluation and Follow Up Care. **The Contact Lens Evaluation fee is between $60 and $100 in addition to a routine vision exam.** Insertion and removal training for new contact lens patients is an additional one-time fee of $20. Payment is due upon completion of service. If you participate in a flex spending account, please request a receipt. For your convenience we accept: Cash, Check and Credit Card.

Vision Insurance _____

Subscriber Name _____

Subscriber ID# _____

Subscriber Birth Date _____

Medical Insurance _____

Subscriber Name _____

Subscriber ID# _____

Subscriber Birth Date _____

VERY IMPORTANT! NEW PATIENTS ONLY:

How did you choose our office?

❑ Insurance List ❑ Saw Sign/Building ❑ Web Page:
Which Web Site? _____ ❑ Other _____

Who may we thank for referring you to our office?

Name of friend, relative or Dr. _____

Patient Eye History

Have you ever experienced, been diagnosed or treated for any of the following eye conditions?

❑ Blurry Vision
❑ Cataracts
❑ Crossed eye/Eye turn
❑ Eye Infections
❑ Flash of light
❑ Glaucoma
❑ Headaches
❑ Itchiness
❑ Macular Degeneration
❑ Retinal Detachment
❑ Tearing
❑ Uncomfortable glasses
❑ Other eye disorders _____
❑ Burning
❑ Corneal Abrasions
❑ Double Vision
❑ Eye Injury
❑ Floaters/Spots
❑ Grittiness
❑ Iritis/Uveitis
❑ Lazy Eye
❑ Occasional dryness
❑ Sunlight Sensitivity
❑ Trouble seeing at night

The information in this confidential case history form is critical to the evaluation of your vision and health.

Patient Medical History

Name of Primary Physician_____

City_____

Date of Last Physical Check-up_____

CURRENT MEDICATIONS (Rx or Over the Counter)

(List name of medications including eye drops, vitamins, & birth control pills) _____

_____

_____

Allergies to medications? ❑ Yes ❑ No

If so, what medications?_____

_____

Have you had any surgeries? ❑ Yes ❑ No

Do you use cigarettes/tobacco, alcohol, or other substances? ❑ Yes ❑ No

Have you ever been diagnosed or treated for the following health problems?

❑ Allergies	❑ Arthritis
❑ Blood/Lymph	❑ Bronchitis
❑ Cancer	❑ Cholesterol
❑ **Diabetes**	❑ Digestive
❑ Ears/Nose/Throat	❑ Endocrine
❑ Eczema/Rashes	❑ Fatigue
❑ Fevers	❑ Genitourinary
❑ High Blood Pressure	❑ Headaches
❑ Kidney	❑ Muscle/Bone
❑ Neurological	❑ Psychological
❑ Respiratory	❑ Sinus
❑ Throat Infections	❑ Thyroid
❑ Unusual weight losses/gains	

Patient Eye History

Date of Last Eye Exam_____

Where? _____

Do you currently wear glasses? ❑ Yes ❑ No

Are you satisfied with the vision and comfort of your current glasses? ❑ Yes ❑ No

If you wear bifocals, do the lines or head tilting bother you? ❑ Yes ❑ No

Do you currently wear contact lenses? ❑ Yes ❑ No

What kind?_____

Solutions used_____

Are you satisfied with the vision and comfort of your current contact lenses? ❑ Yes ❑ No

Family Medical/Eye History (Check all that apply)

Is there a family medical history of any of the following:

	Relationship (Mother's or Father's side)
Blindness	❑_____
Cataracts	❑_____
Corneal Problems	❑_____
Diabetes	❑_____
Glaucoma	❑_____
Heart Disease	❑_____
Lazy Eye	❑_____
Macular Degeneration	❑_____
Retinal Problems	❑_____

Insurance Authorization - Signature on File

Please be advised if you are using insurance coverage for today's visit, this is a contract between you and your insurance company, not Crystal Clear Eye Care. **Verification, benefits and authorizations received from your insurance company are not a guarantee of payment.** Final determination of your benefits is made when your insurance company receives your claim. Therefore, ***the amount you will pay today is your estimated portion***. **If your insurance company has not reimbursed our office in full within 90 days, you will be billed.**

I authorize Crystal Clear Eye Care to act as my agent in helping me obtain payment from my insurance carriers. I authorize payment directly to Crystal Clear Eye Care. I permit a copy of this authorization to be used in place of the original. My signature verifies that I have reviewed a copy of the HIPAA Notice of Privacy Practices Statement.

X_____

(Signature of Responsible Party)