Carolinas Vision Group
carolinas vision group, o.d., p.l.l.c.
eyecare · lasik · eyewear · contacts

We welcome you...

Patient's Name: _____ Mr. Mrs. Ms. Miss Dr. Rev Gender: M F

Marital Status: Single Married Divorced Widow Nick Name: _____ Patient's Date of Birth: _____

SSN: _____ Race: White/ Caucasian Black /African American Hispanic Asian/ Pacific Islander Other: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____

Email address: _____

Communication Preference: Phone Email Postal Mail Text

Name of Employer/School: _____ Occupation/Grade: _____

Name of Spouse/Parent: _____ Date of Birth: _____

Medical History

	Self:	Family (Specify who):
Diabetes	☐	☐ _____
Heart Disease	☐	☐ _____
Cancer	☐	☐ _____
High Blood Pressure	☐	☐ _____
High Cholesterol	☐	☐ _____
Other:_____	☐	☐ _____
Cataracts	☐	☐ _____
Glaucoma	☐	☐ _____
Macular Degeneration	☐	☐ _____
Other:_____	☐	☐ _____

Medications: _____

_____

Medication Allergies: _____

Previous Eye Doctor/Practice Name: _____
Date of last exam: _____

Family Physician/Pediatrician/Practice Name: _____
Practice Phone Number: _____

Insurance Information

Employer Name: _____

Vision Insurance: _____ Ins Phone #: _____ ID# _____

Medical Insurance: _____ Ins Phone #: _____ ID # _____

Secondary Insurance (Medicare): _____ Ins Phone #: _____

Policy Holder's Name: _____ Date of Birth: _____ SSN: _____

How did you hear about our office? Website Insurance Company Yellow Pages Patient Referral

Please list the name of the person who referred you to our office: _____, so we can send a special Thank You.

_____ _____
Patient or Guardian Signature Date

(Please note: we will not sell or give out your information or email address. It is for our use only. With your permission we will only use your email for appointment reminders, office communication and notification of our current promotions.)

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Name of Patient _____ **Date of Birth** _____

Section 1: Acknowledgement of Notice of Privacy Practices

The state of North Carolina requires **Carolinas Vision Group** to make every effort to inform you of your rights and what is being released related to your personal health information. I hereby acknowledge that I have received or was offered a copy of Carolinas Vision Group's privacy policy.

Patient's Signature: _____ Date: _____

OR Legal Guardian/Representative's Signature: _____

Printed Name: _____ Relationship to patient: _____

Section 2: Authorization for Release of Information – Compound Release

Carolinas Vision Group is authorized to release protected health information about the above-named patient in the following manner and to identified persons.

Check each method that YOU approve to receive YOUR information. (Please provide YOUR phone number and email address)	**Check each that can be given to method on the left in the same section.**
☐ Voice Mail	☐ Appointment Confirmation ☐ Appointment Reminder ☐ Financial ☐ Medical
☐ Text Message	☐ Appointment Confirmation ☐ Appointment Reminder ☐ Financial ☐ Medical
☐ Email Communication	☐ Appointment Confirmation ☐ Appointment Reminder ☐ Financial ☐ Medical
Write each person OTHER than you that you approve to receive information. (i.e. Spouse, Parent, Friend, Relative etc.) (Please provide THEIR name and phone number) **NAME** **PHONE NUMBER**	**Check each that can be given to person on the left in the same section.**
	☐ Appointment Information ☐ Financial ☐ Medical
	☐ Appointment Information ☐ Financial ☐ Medical
	☐ Appointment Information ☐ Financial ☐ Medical

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.
- This authorization will remain in effect until revoked by the patient.
-

_____ Date _____

Signature of Patient or Personal Representative

*Description of Personal Representative's Authority (attach necessary documentation)

CAROLINASVISIONGROUP

Lifestyle Questionnaire...

We know that this feels like more paperwork, but your doctor really wants to understand more about your visual needs. Please take a minute to fill this out so we can better accommodate you. Thank You!

Name: _____Date: _____

What DO you like about your current pair(s) of glasses?

_____

_____

What DON'T you like about your current pair(s) of glasses?

_____

_____

Does your work entail visual demands due to any of the following:

- ☐ Computer use. Hours per day _____
- ☐ Distance viewing/Driving
- ☐ Near viewing/Reading
- ☐ Abrupt changes in light levels
- ☐ Exposure to flying objects
- ☐ Dusty environment
- ☐ Other _____

What are your favorite hobbies/recreational activities? (check all that apply)

- ☐ Computer
- ☐ Sewing/needlepoint
- ☐ Fishing/boating/water sports
- ☐ Golf
- ☐ Tennis or other racquet sports
- ☐ Woodworking
- ☐ Gardening
- ☐ Music. Do you play an instrument? _____
- ☐ Other _____

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Are you bothered by glare from any of the following:

- ☐ Night driving/headlights
- ☐ Sunshine/UV exposure
- ☐ Hazy conditions
- ☐ Fluorescent lights
- ☐ Computer screens
- ☐ Other _____

Do you wear contact lenses? (Circle type)

- ☐ Yes
- ☐ No

Soft Lenses Hard Lenses

Daily Wear Overnight Wear Colored or tinted

Are you interested in contact lenses, even if it is only for occasional use?

- ☐ Yes
- ☐ No

Do you currently use more than one pair of glasses?

- ☐ Yes
- ☐ No

If so, is your second pair of glasses for a particular reason? (check all that apply)

- ☐ Hobby/recreational activity

  _____
- ☐ Sports/protective eyewear

  _____
- ☐ When driving
- ☐ Prescription sunglasses
- ☐ Occupational eyewear
- ☐ Reading glasses
- ☐ Evening/comfort wear
- ☐ Fashion wear
- ☐ Other _____

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Financial Policy and Benefit Assignment

We are committed to assisting you with timely insurance filing and payment of your account. I understand that I am financially responsible for payment of all charges, whether or not paid by insurance, including any charges for services rendered which are denied, not previously authorized, or for any reason not covered by the applicable insurance company. This may include co-payments, deductibles, and co-insurance not covered by my insurance.

If for any reason I feel that my claim has been inaccurately denied for any reason other than an error on Carolinas Vision Group's part, I will be responsible for disputing the claim with my insurance company. If a referral is required and I choose to be seen without it, I agree to be responsible for all charges incurred if denied by my insurance.

A service charge of $25 will be added for all checks returned for any reason, including non-sufficient funds. Payment for professional services will be due in full the day services are provided to you. I understand that every pair of eyewear made by Carolinas Vision Group is custom made to each patient's needs. For this reason, Carolinas Vision Group cannot accept returns or frame restyles. In the event that I may receive a refund, I may be charged a restocking fee of 30%. If I choose to restyle to a different frame or lens design that is more expensive than the original, I will need to pay the difference in cost. In the event that I choose a less expensive frame or lens design, fees will be retained by Carolinas Vision Group.

Patient's Signature: _____ Date: _____

OR Legal Guardian/Representative's Signature: _____

Printed Name: _____ Relationship to patient: _____