Alabama Vision Center, L.L.C.

Price Kloess, M.D. / Andrew J. Velazquez, M.D.

Patient Registration and Financial Agreement

Patient's Name: Dr / Miss / Mrs / Mr ____
Street Address: ____
City: ____________________________ State: ___________ Zip Code: ___________________
Social Security Number: ______-____-______ Sex: M / F Single / Married / Widowed / Divorced
Date of Birth: ________________ Age: ______ Email Address: __________________________
Home Phone: ______________________________ Cell Phone: ____________________________
Employer: _______________________________ Occupation: ______________________________
Employer's Phone: _____________________________ Fax: ______________________________
Referred by :____

Insured Party Information

(please complete if the insurance is **not** in your name**)**

Name: _______________________________ Date of Birth: ___________ Relationship: ________
Street Address: ____
City: ___________________________________ State: _______ Zip Code: ________________
Employer: _____________________________________ Phone: ____________________________

Emergency Contact Information

Name: ____________________________ Phone: (   ) _____-_______ Relationship: __________
Name: ____________________________ Phone: (   ) _____-_______ Relationship: __________

Insurance Information

Do you have an insurance plan specifically for vision coverage? YES / NO
If so, who is your vision plan provider? ____
Insurance: Company Name: ____
Contract No.: _______________________________ Group No.: _______________

ALL PATIENTS: I understand that the charges made by the Alabama Vision Center for professional services may not be covered in full by any insurance covering such services to the patient. The patient and/or the party responsible for payment of fees for services rendered to the patient agree to make payment in full to the Alabama Vision Center in such cases. The undersigned accepts the fee charged as a lawful debt and promises to pay said fee including up to 35% of the debt for the cost of collection, in addition to attorney's fees, and court costs if such be necessary, waiving now and forever the right to claim exemption under the constitution and laws of the state of Alabama or any other state.
I understand that I am required to pay any health insurance deductibles, co-insurance, co-payments, or any other charges incurred which are not paid by insurance.

I understand that Medicare, Blue Cross and other insurances may or may **not** cover refractions, after hours services or other services that the doctor feels will be necessary for the treatment of my condition and/or maintenance of good health. If I receive a refraction, receive care after hours or other non covered service by my insurance today and any visits in the future, I do agree to pay for these services in full.

I authorize release of any medical information necessary to process an insurance claim and wish to receive updates in medical information via email.

All payment is due at the time services are rendered.

SIGNATURE: ____ DATE: _______________

Date________________

Name___________________________________Birthdate___________Sex_____Age____
Referred by____

EYE HEALTH HISTORY

Date of last visit_____________

Date of last eye exam________

Name of doctor_____________

Do you wear glasses?□Yes □No
□All the time □Occasionally
□Reading □Driving □TV

Do you wear contacts?□Yes □No
Type___________________
Hours/Day_______________

Place a mark on "Yes" or "No" to indicate if you have had the following:

Condition			Condition		
Bloodshot Eyes	□Yes	□No	Floaters or Spots	□Yes	□No
Blurred Vision – Distance	□Yes	□No	Glaucoma	□Yes	□No
Blurred Vision – Near	□Yes	□No	Headaches	□Yes	□No
Burning Eyes	□Yes	□No	Itching Eyes	□Yes	□No
Cataracts	□Yes	□No	Light Sensitive	□Yes	□No
Color Vision, Poor	□Yes	□No	Loss of Vision	□Yes	□No
Crossed Eyes	□Yes	□No	Migraine Headaches	□Yes	□No
Discharge from Eyes	□Yes	□No	Night Vision, Poor	□Yes	□No
Dizzy Spells	□Yes	□No	Red Eyes	□Yes	□No
Double Vision	□Yes	□No	Seeing Halos	□Yes	□No
Dry Eyes	□Yes	□No	Seeing Flashes	□Yes	□No
Eye Infection	□Yes	□No	Temp Loss of Vision	□Yes	□No
Eye Injury	□Yes	□No	Twitching Eyelid	□Yes	□No
Eye Strain	□Yes	□No	Vision Poor	□Yes	□No
Fainting Spells, Blackouts	□Yes	□No	Watering Eyes	□Yes	□No

Describe any problems you have
with your contacts____
____
____

HEALTH HISTORY

Physician's Name_________________________________Date of Last Visit____________________

Place a mark on "Yes" or "No" to indicate if you have had any of the following. Also place a mark to indicate if a blood relative has had any of the following problems:

	Yourself		Family Members	
AIDS/HIV	□Yes	□No	□Yes	□No
Arthritis	□Yes	□No	□Yes	□No
Artificial Heart Valve	□Yes	□No	□Yes	□No
Artificial Joints	□Yes	□No	□Yes	□No
Asthma	□Yes	□No	□Yes	□No
Bleeding	□Yes	□No	□Yes	□No
Blindness	□Yes	□No	□Yes	□No
Cancer	□Yes	□No	□Yes	□No
Cataracts	□Yes	□No	□Yes	□No
Chemical Dependency	□Yes	□No	□Yes	□No
Diabetes	□Yes	□No	□Yes	□No
Drug Sensitivity	□Yes	□No	□Yes	□No
Emphysema	□Yes	□No	□Yes	□No
Epilepsy	□Yes	□No	□Yes	□No
Eye Surgery	□Yes	□No	□Yes	□No
Glaucoma	□Yes	□No	□Yes	□No
Hay Fever	□Yes	□No	□Yes	□No
Heart Condition	□Yes	□No	□Yes	□No

	Yourself		Family Member	
Hepatitis (Type_______)	□Yes	□No	□Yes	□No
High Blood Pressure	□Yes	□No	□Yes	□No
Kidney Disease	□Yes	□No	□Yes	□No
Lazy Eye	□Yes	□No	□Yes	□No
Lupus	□Yes	□No	□Yes	□No
Migraine Headaches	□Yes	□No	□Yes	□No
Pacemaker	□Yes	□No	□Yes	□No
Poor Color Vision	□Yes	□No	□Yes	□No
Retinal Disease	□Yes	□No	□Yes	□No
Rheumatic Disease	□Yes	□No	□Yes	□No
Shingles	□Yes	□No	□Yes	□No
Skin Conditions	□Yes	□No	□Yes	□No
Stroke	□Yes	□No	□Yes	□No
Thyroid Conditions	□Yes	□No	□Yes	□No
Tuberculosis	□Yes	□No	□Yes	□No
Turned Eye	□Yes	□No	□Yes	□No

Are you pregnant?_________ Number of children________
Tobacco use______________Alcohol use______________

MEDICATIONS | ALLERGIES

List medications you are currently taking, including eye drops: ____________________________________
____
____
____

List your allergies to medications or other substances:
____
____
____
____

Pharmacy Name_____________________________

Pharmacy Phone # ____________________________

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Date: __________

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To better serve you, please review and circle all of the following items you are interested in learning about during this exam or evaluation:

LASIK (Laser In Situ Keratomileusis)

PRK (Photorefractive Keratectomy)

EpiLASIK (Advanced Surface Ablation)

Cataracts & Cataract Surgery

If you are here for a cataract evaluation, how important is it for you to see without glasses after cataract surgery?

____ Very Important ____ Somewhat Important
____ Important ____ Not Important

Which of the following activities would you like to do without glasses?

____ Read the newspaper ____ Read a prescription medicine bottle
____ Read a book or recipe ____ Put on your make-up ____ Shave

Glaucoma

Smart Multi-focal Intraocular Lenses (ReSTOR and ReZoom)

Monovision / Correction of Presbyopia (the need for reading glasses)

Correction of astigmatism

Phakic Intraocular Lenses (for extreme nearsightedness)

Improving vision after refractive surgeries such as Radial Keratotomy (RK)

CRT (Cornea Refractive Therapy for non-surgical refractive candidates)

Obtaining: Glasses Sunglasses Contacts Lenses

Other primary vision interests or concerns: ____

____

Thank You