ViewPoint Optometry

10800 East 21st North
Wichita, KS 67206
(316) 634-1987

2727 North Maize Road
Wichita, KS 67205
(316) 722-1695

NAME: _____ DOB: _____ Gender: M/F

Address:_____ City/State:_____ZIP: _____
Preferred Phone #:_____ Circle: Home/Cell/ Work Permission to text: Y/N
Email: _____ Permission to email: Y/N
Occupation:_____ Referred by:_____

If Under 18 years old - Parents:_____
Address (if different than above):_____
Parent Preferred #: _____ Parent email: _____

Please list family members who are patients here: _____

INSURANCE INFORMATION
Policy Holder's Name: _____ DOB: _____ SSN: _____
Vision Insurance:_____ Medical Insurance: _____
Policy/Member ID#: _____ Policy/Member ID#: _____
Group #: _____

OCULAR HISTORY
Date of Last Eye Exam:_____ Name of Last Optometrist: _____
Do you wear glasses? Y/N What type of sun protection do you currently wear? _____
Have you ever worn contact lenses? Y/N Which brand and care system? _____
Current eye drops: _____ Allergies to Eye Drops:_____

MEDICAL HISTORY
Last Medical Exam: _____ Name of Medical Doctor: _____
List all Medications:_____
_____
Do have allergies to any medicines? Y/N Explain:_____

PRIMARY COMPLAINT Please circle any symptoms you are experiencing:
Annual eye exam Blurred vision Tired eyes Watery eyes Sandy/gritty feeling Dry eyes Red eyes
Glare/Light sensitive Itchy eyes Floaters Flashes of light Eye soreness/pain Double vision
Lazy eye Crossed eye Other: _____
Onset of symptoms:_____

(Please continue on other side)

REVIEW OF SYSTEMS Do you currently, or have you had any problems in the following areas? Please circle.

Ear/Nose/Throat
- Hearing Loss
- Sinus Congestion
- Ear Infections

Neurological
- Multiple Sclerosis
- Epilepsy
- Stroke
- Migraine

Psychiatric
- Anxiety
- Depression
- Attention Deficit

Respiratory
- Asthma
- Bronchitis
- Emphysema
- Sleep Apnea

Gastrointestinal
- Crohn's Disease
- Colitis
- Acid Reflux
- Celiac Disease

Genitourinary
- Kidney disease
- Prostate disease
- UTI

Musculoskeletal
- Rheumatoid Arthritis
- Fibromyalgia
- Osteoporosis
- Gout

Cardiovascular
- Hypertension
- Heart Disease
- Vascular Disease

Hematologic/Lymphatic
- Anemia
- High Cholesterol
- Clotting Disorder

Endocrine
- Type I Diabetes Mellitus
- Type II Diabetes Mellitus
- Thyroid Dysfunction

Integumentary
- Eczema
- Rosacea
- Psoriasis
- Herpes Simplex/Cold Sores
- Herpes Zoster/Shingles

Other/Not Listed:_____
_____
_____
_____

FAMILY HISTORY If you have parents, siblings, or children with any of the following, please circle condition.

Hypertension Diabetes – Type 1 or 2 Cancer Thyroid Cataract Glaucoma
Macular Degeneration Amblyopia (Lazy eye) Strabismus (Crossed Eyes) Retinal Detachment

---

CONSENT FOR TREATMENT: I hereby authorize ViewPoint Optometry to administer diagnostic and medical procedures as may be necessary for proper health care.

ACKNOWLEDGEMENT OF RECEIPT OF HIPPAA NOTICE OF PRIVACY PRACTICES: I have been offered a copy of ViewPoint Optometry's Notice of Privacy Practices.

MEDICARE AUTHORIZATION: I request payment of authorized Medicare benefits be made on my behalf to ViewPoint Optometry, for any service furnished to me by the doctor. I authorize the holder of medical information about me to release to Medicare or any other insurance that I may have any information needed to determine these benefits or the benefits payable for related services. In Medicare assigned cases, the doctor agrees to accept the charge determination of the Medicare carrier at full charge and the patient is responsible only for the deductible, co-insurance, copays, and uncovered services. Copays, co-insurance, and the deductible are based on the charge determination of the Medicare carrier.

_____ (Initial Here) **I have read and understand all office policies and if a medical diagnosis is determined, my vision insurance may not cover the examination, and the examination will be billed to my medical insurance. I will be subject to all deductibles, co-insurance, and copays related to the examination as determined by the medical insurance carrier.**

_____ _____

Patient or Legal Guardian Signature Date

ViewPoint Optometry

10800 East 21st North
Wichita, KS 67206
(316) 634-1987

2727 North Maize Road
Wichita, KS 67205
(316) 722-1695

Office Policies and Financial Agreement

Full Payment Required

Full payment is required for services rendered. It is my responsibility to pay any deductible, co-insurance, copay, or any other balance not paid by my insurance company, and I authorize insurance benefits to be paid directly to ViewPoint Optometry**. Copays will be paid in full on day of examination.**

Proof of Insurance

Insurance must be provided at time of service in order for a claim to be filed. If requested, ViewPoint Optometry will provide a detailed itemized receipt that can be submitted to insurance by the patient.

Cancellations

24 hour notice is required for any cancellation and/or rescheduling. Otherwise a $30 cancellation fee may be incurred.

Routine Exam

Patients presenting with a medical condition that prevents an accurate glasses prescription may be required to reschedule the routine exam until a later date when the condition has been resolved.

Glasses Prescriptions by ViewPoint Optometry

An office visit to recheck the prescription will be provided at no charge within 90 days of the examination. Re-check visits after 90 days will be charged the usual fee for a refraction. If a ViewPoint Optometry prescription is filled outside of Target Optical and a prescription change is needed, ViewPoint Optometry will not be responsible for any charges incurred in remaking the lenses.

Returned Check Fee

A fee of $40 will be charged for each returned check.

Collections of Past Due Accounts

If your account becomes past due, we will try to collect this debt by sending invoices. If all other attempts fail, your account may be referred to a collections agency as a last resort. If this action is required, you are liable for any collections costs, court costs, and reasonable attorney fees.

Professional fees, such as exam, contact lens and vision therapy fees, represent payments for services that were rendered (even if not successful) and are not refundable.

Patient's Name_____

Signature of Patient or Guardian _____ Date_____