Office Use Only
J / R _____
New Pt _____
Last exam _____

Welcome to Garden City VisionSource!

Patient information.

*In order for us to be able to contact you and submit your insurance claims, we must have your **EXACT, CURRENT** personal information. Your insurance company will **deny** your claim unless **all information is current and exact**. Please fill in your current personal information.*

(Please Print)

Name _____ Social Security # _____
First Middle Initial Last

Address _____ City _____ State _____ Zip _____

Birthdate _____ Age _____ Male _____ Female _____E-mail_____

Home Phone (____)_____Work Phone (____)_____Cell Phone (____)_____

Patient Employer/School _____ Occupation/Grade_____

Marital Status: ☐Married ☐Single ☐Other

Employment Status: ☐ Employed ☐Part time Student ☐ Full time Student ☐Other

Spouse or parent's name _____Employer _____ Work Phone (____)_____

Whom may we thank for referring you to us? _____

Responsible Party

Name of person responsible for this account _____ Birthdate_____

Relationship to Patient _____ Phone (____)_____ Social Security # _____

Address _____ City _____ State _____ Zip _____

Name of Employer _____ Work Phone (____) _____

Insurance Information

Name of Policy Holder _____ Relationship to patient _____

Birthdate _____ Social Security # _____

Insurance Company _____

Payment Information: **Payment is required in full** for services the day you are seen.

Insurance Disclaimer: I hereby authorize payment of my medical, surgical and/or vision insurance benefits to Garden City Vision Source. I understand I am financially responsible for any charges whether or not paid by said insurance. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Garden City Vision Source. I authorize Garden City Vision Source to release any information required to process any and all claims for reimbursement on my behalf. A copy of this authorization may be used in place of the original.

Returned Check Policy: Any checks returned to us for insufficient funds will automatically be turned over to Bartlett & Selzer Collection Specialist with an additional $30 fee.

(more on back)

Personal and Ocular Health. Dr Johannes and Dr. Reimer ask that you complete this table with your current health conditions. It is very important that your doctor knows about these health conditions in order to make the best medical decisions for you. Even if you are already a patient here, please complete the following questions concerning your health status.

What vision problems or eye health problems are you experiencing?
Please list all medications you are taking:
Do you have any allergies or allergies to medication? **If yes, what type of allergic reactions have you experienced?*
Please list all of your general health problems:
Please list all eye diseases in your immediate family:
Have you had any eye surgeries?
Do you use alcohol/tobacco? **If yes, how often?*

Do you currently have any of the following symptoms? If yes, please explain.

Chronic fever, unexpected weight gain/loss, fatigue	__ No __ Yes	_____
Ear, nose or throat problems (sinus problems, sore throat)	__ No __ Yes	_____
Heart problems (e.g. chest pain, irregular heart beat)	__ No __ Yes	_____
Respiratory problems (e.g. asthma, wheezing, coughing)	__ No __ Yes	_____
Gastrointestinal problems (e.g. heartburn, diarrhea, vomiting)	__ No __ Yes	_____
Urinary problems (e.g. pain or discomfort, blood in urine)	__ No __ Yes	_____
Skin problems (e.g. rashes, excessive dryness, acne)	__ No __ Yes	_____
Musculoskeletal problems (muscle aches, joint pain, swollen joints)	__ No __ Yes	_____
Neurological problems (e.g. numbness, weakness, headaches)	__ No __ Yes	_____
Psychiatric problems (e.g. depression, anxiety)	__ No __ Yes	_____
Blood/Lymph problems (e.g. cholesterol, anemia)	__ No __ Yes	_____
Allergy/Immunology problems (e.g. hay fever, lupus, Sjogren's)	__No __Yes	_____

Acknowledgement of Receipt:

I acknowledge that I received a copy of Dr. Johannes and Dr. Reimer's Notice of Privacy Policies and I acknowledge that I understand the previously stated financial policies.

Refund Policy: In the case of materials being returned for a refund after we have exhausted all measures to ensure proper fitting within the first two weeks of dispense, refunds will be given in the form of a check deducting any charges incurred by our lab.

Patient Name: _____

Signature: _____ Date: _____