AVON VISION CENTRE

We are pleased to welcome you to our practice. Please fill out this form as completely as you can. If you have any questions we will be happy to assist you.

PATIENT INFORMATION

Date_____

Patient_____

Address_____

_____
City State Zip

Sex: Male Female Age_____DOB_____
Marital Status Single Married Divorced Widowed
Patient SSN#_____
Occupation_____
Employer_____
Employer Address_____
Spouse's Name_____
Birth Date_____SSN#_____
Occupation_____
Whom may we thank for referring you?
_____

INSURANCE INFORMATION

Who is responsible for this account?
_____
Relationship to Patient_____
Insurance Co._____
Group#_____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with_____and assign directly to **Dr. Oberg and or Avon Vision Centre**, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

_____
Responsible Party Signature

_____
Relationship Date

PATIENT CONTACT INFORMATION

Home_____Work_____Cell_____Email Address_____

Best time and place to reach you_____

IN CASE OF EMERGENCY, CONTACT:

Name_____ Relationship_____

Home Phone_____Work Phone_____

Physician's Name_____
Date of last visit_____
Date of last eye exam_____
Do you wear glasses YES NO
Do you wear contacts YES NO
Type_____Hrs/Day_____
Solution used_____

OCULAR HEALTH HISTORY

- ☐ Blurry Vision Distance
- ☐ Blurry Vision Near
- ☐ Eye Strain
- ☐ Headaches
- ☐ Light Sensitivity
- ☐ Double vision
- ☐ Flashes of Light
- ☐ Floaters or Spots
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Loss of Vision
- ☐ Macular Degeneration
- ☐ Dry Eyes
- ☐ Itchy/Burning
- ☐ Red Eyes
- ☐ Ocular Allergies
- ☐ Discharge From Eyes
- ☐ Injury, type_____

HEALTH HISTORY

Physician's Name_____ Date Of Last Visit_____
Are You Pregnant_____Number Of Children_____
Tobacco Use_____Alcohol Use_____

	Yourself		Family Members	
AIDS/HIV	☐ Yes	☐ No	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	☐ Yes	☐ No
Arthritis	☐ 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
Cholesterol	☐ Yes	☐ No	☐ Yes	☐ No
Depression	☐ 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

	Yourself		Family Members	
Eye Surgery	☐ Yes	☐ No	☐ Yes	☐ No
Hay Fever/Allergies	☐ Yes	☐ No	☐ Yes	☐ No
Heart Condition	☐ Yes	☐ No	☐ Yes	☐ No
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
Retinal 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

CURRENT MEDICATIONS

List ALL medications you are currently taking, including eye drops:

_____
_____
_____
_____
_____
_____

ALLERGY HISTORY

List your allergies to medications or other substances:

_____
_____
_____
_____
_____
_____

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to DR. JEFFREY A. OBERG AND OR AVON VISION CENTRE for any services furnished me by the doctor. I authorize any holder of medical information about me to release to Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act, is correct.

_____

Signature of Beneficiary **Date**

Thank You