Patient Name: Date of Birth:

Briefly describe your main concern today: _____

Do you presently wear glasses? Yes No Do you plan on purchasing glasses today? Yes No

Do you wear contacts? Yes No Would you like a Contact Lens Evaluation? Yes No

When was your last eye exam? _____ Where? _____

Primary Care Physician's Name: _____ Your Last Visit: _____

Have you experienced any of the following eye/vision problems? (if yes please describe)

Previous Eye Injury Yes No _____
Previous Eye Surgery Yes No _____
Double Vision Yes No _____
Excessive Irritation Yes No _____
Excessive Tearing Yes No _____
Flashes of Light Yes No _____
Loss of Vision Yes No _____

How many hours per day do you spend on the computer? _____

Have you ever been diagnosed as having any of the following?

Allergies	Yes	No	Cancer	Yes	No	Type of Cancer _____		
Thyroid Problem	Yes	No	Diabetes	Yes	No	Blood Sugar Ranges: _____		
Muscle/Joint Pain	Yes	No	Respiratory Problem	Yes	No	Migraines	Yes	No
High Blood Pressure	Yes	No	High Cholesterol	Yes	No	Heart Disease	Yes	No

Please list your current medications (Prescriptions, Non-Prescriptions, Home Remedies, Vitamins, etc)

_____ _____ _____
_____ _____ _____
_____ _____ _____

Are you allergic to any medications? Yes No Describe: _____

Have you been diagnosed with any of the following? (Circle any that apply)

Glaucoma Cataracts Macular Degeneration

Do you have any other eye/vision or health problems (other than the need for glasses)?

_____

Do you smoke? Yes No How many packs a day? _____ Are you trying to quit? Yes No

Has anyone in your family ever been diagnosed as having any of the following?

Blindness	Yes	Who: _____	Cancer	Type _____	Who: _____
Macular Degeneration	Yes	Who: _____	Diabetes		Who: _____
Retinal Detachment	Yes	Who: _____	Heart Disease		Who: _____
Glaucoma	Yes	Who _____	High Blood Pressure		Who: _____

Do any other eye or health problems run in your Family? _____

Welcome to

DEMERS
FAMILY VISION GROUP, INC.

Patient Information

Patient Name _____ DOB _____

Address _____ Social Security # _____

City _____ State _____ Zip Code _____ ○ Male ○ Female

Home Phone _____ Cell _____ Work _____

Fax _____ Email Address _____

Employer _____ Occupation _____ ○ Married ○ Single ○ Widowed

**Would you like to receive email updates on promotions, new additions, or important information regarding our services or materials?* ○ *Yes* ○ *No*

How did you hear about us? ○ www.DeMersvision.com ○ Yellow Pages ○ Other Website

○ Walk-In ○ Dr. Referral_____ ○ Patient Referral _____ ○Established

Guarantor Information

**Complete if patient is *younger* than 18 years of age

Legal Guardians Name _____ Date of Birth _____

Address _____ Social Security # _____

Phone Number _____ Cell Phone _____

Email Address _____ Employer _____

**Would you like to receive email updates on promotions, new additions, or important information regarding our services or materials?*
○ *Yes* ○ *No*

Insurance Information

○ VSP ○ Medicare ○ Medicaid ○ None ○ Other

Primary Member on Insurance _____ Relationship to Patient _____

Primary Members Date of Birth _____ Primary Member Social Security # _____

Primary Member Employer _____

***Please have your insurance card available for the receptionist to scan*

DEMERS

FAMILY VISION GROUP, INC.

By signing, I agree to the following:

HIPAA - I have been given the opportunity to read the HIPAA privacy policy. By way of my signature, I acknowledge that DeMers Family Vision Group has given me the opportunity to have a copy of the policy that includes information regarding the use and disclosure of my protected health care information for the purpose of treatment, payment, and health care operations. A copy shall be as valid as the original.

X_____ Date:_____

ALL PATIENTS - In consideration for the professional services and materials rendered to me at my request, I agree to pay my portion of deductibles, co-pays, and/or the remaining balance not covered by my insurance company. I understand that it is my responsibility to know my insurance benefits before my appointment and that I am liable for any charges they deny.

X_____ Date:_____

INSURANCE ABN - I request that payment of authorized insurance benefits be made on my behalf to DeMers Family Vision Group, for services furnished me by DeMers Family Vision Group. I authorize any holder of medical information about me to release to my insurance company and its agents any information needed to determine these benefits payable for related services. I understand my signature requests that payment be made and authorizes the release of my medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. DeMers Family Vision Group accepts the charge determination of my carrier as the full charge, and I am responsible only for the deductible, coinsurance and any non-covered services. Coinsurance and deductible are based upon the charge determination of my primary insurance carrier.

X_____ Date:_____

FAMILY VISION GROUP, INC.
670 N. McCarran Blvd
Sparks, NV 89431
(775) 358-1317

PATIENT AUTHORIZATION FORM

Many of our patients allow family members such as their spouse, significant other, parents or children to call and request the result of tests, procedures and financial information. Under the requirements for H.I.P.A.A. we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, any diagnostic test results and/or financial information released to any family members you must sign this form. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Name:	Relationship to Patient:
1.	
2.	
3.	

AUTHORIZATION TO TREAT A MINOR

I, _____, authorize the following person(s) to bring my child, _____, in for the course of medical evaluation and treatment during my absence. This person will be known as a Patient Representative. I further allow this individual(s) to authorize any medical procedures in the event of emergency.

Name of Representative:	Relationship to Patient:
1.	
2.	
3.	

_____ _____

Patient/Legal Guardian Relation to Patient

_____ _____

Patient/Legal Guardian Signature Date