# Welcome to Jarvis Vision Center!

Please fill out the following information to the best of your ability.
Ask for assistance if needed.

JARVIS VISION CENTER

## Personal Information

Name: _____ Date of Birth: _____

Street Address: _____ Social Security #: _____

City, State, Zip: _____ Sex: M ☐ F ☐

Spouse/Parent's Name: _____ Spouse Date of Birth: _____

Employer: _____ Spouse Employer: _____

Primary Language: English ☐ Spanish ☐ Other, please specify: ☐

Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐

## Communication

Home phone #: _____ Work phone #: _____

Cell phone #: _____ Email Address: _____

Preferred method of communication Text ☐ Phone ☐ Email ☐ Mail ☐

May we contact you via email or text? Y ☐ N ☐

## Referrals

How did you hear about our office? _____

Who can we thank for referring you today? _____

## Insurance Information

**Vision Ins. Company Name:** _____

Policy #: _____ Group #: _____

Name of Insured: _____ SS#: _____ DOB: _____

**Medical Ins. Company Name:** _____

Policy #: _____ Group #: _____

Name of Insured: _____ SS#: _____ DOB: _____

## Personal Ocular History

Primary Eye Care Doctor: _____ Last Visit: _____

Do you currently wear glasses? Y ☐ N ☐ Date of current pair: _____

Do you wear contact lenses? Y ☐ N ☐ Brand of contacts: _____

How often do you replace them? Daily ☐ Monthly ☐ Other: _____

**Have you ever been diagnosed with the following conditions? Check all that apply:**

| | | |
|---|---|---|
| Glaucoma ☐ | Cataracts ☐ | Macular Degeneration ☐ |
| Dry Eyes ☐ | History of Eye Infections ☐ | History of Eye Injuries ☐ |
| History of Eye Surgeries ☐ | Lazy eye/Cross eyes ☐ | Diabetic Eye Disease ☐ |

## Personal Health History

Primary Care Doctor: Last Visit:

Approximate Height: ft in Weight: lbs

## Medications

Please list or attach all prescription and non-prescription medications/supplements taken regularly:

What is your preferred pharmacy?

## Allergies

Please list all known allergies.

## Social History

Do you use tobacco products? Y N Do you drink alcohol? Y N

Are you currently pregnant? Y N Due Date:

## Diabetic History

Age when diagnosed: Doctor treating your diabetes:

Last Blood Sugar Reading: Date:

Last Hemoglobin A1C: % Date:

**Have you ever been diagnosed with the following conditions? Check all that apply:**

| | | | |
|---|---|---|---|
| Diabetes | Thyroid | Bleeding Disorder | High Blood Pressure |
| High Cholesterol | Heart Disease | Stroke | Migraines |
| Sinusitis | Asthma | COPD | Colitis/Crohns |
| Arthritis | Lupus | Menopause | Depression |
| Sleep Apnea | Skin Cancer | Other Cancer | Other Conditions |

## Family Health History

**Has anyone in your immediate family been diagnosed with the following conditions? Check all that apply:**

| | Mother | Father | Brother | Sister | Son | Daughter |
|---|---|---|---|---|---|---|
| **Glaucoma** | | | | | | |
| **Cataracts** | | | | | | |
| **Macular Degeneration** | | | | | | |
| **Retinal Disease** | | | | | | |
| **Amblyopia/ Strabismus** | | | | | | |
| **Blindness/Loss of Vision** | | | | | | |
| **Diabetes** | | | | | | |
| **Cancer** | | | | | | |
| **Hypertension** | | | | | | |
| **Thyroid Dysfunction** | | | | | | |

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# Patient Acknowledgement of Financial Responsibility

**Medical Insurance & Vision Plans:**
Jarvis Vision Center is committed to caring for our patient's complete ocular health. We provide both routine vision exams, as well as diagnosis and treatment of eye conditions. Routine vision exams **where there is no medical complaint or diagnosis**, will be filed to your vision plan if applicable. If you have a medical complaint or diagnosis, your exam will no longer be considered routine. In these instances, we are **required** to bill your examination to your medical insurance. Please give all insurance information to check-in upon arrival. It is your responsibility to have all insurance cards at the time of your appointment.

**Contact Lens Evaluation & Fitting:**
Contact lenses are medical devices regulated by the FDA. Your optometrist is required to evaluate the health of your eyes and the fit of your contacts every year in order to determine the best prescription for your eyes. For this service, all contact lens patients will be charged a contact lens fitting and evaluation fee. Most vision and insurance plans require that this be billed separately and do not cover this fee, as contact lenses are considered to be "cosmetic." Patients being fitted with contacts for the first time, who require insertion and removal training or who are being fit with a new contact lens material will be charged $100. Patients previously fit with contacts who require only a new prescription in a previously worn material will be charged $70.

**Patient Responsibilities & Agreement:**
I understand it is my responsibility to know:

- The name of my insurance company
- The amounts of my copays
- My benefits (what is covered and not covered)
- If a prior authorization is required

I understand that any amounts not covered by my insurance for services received are my financial responsibility.

I understand that all copays are due at the time of my appointment. On glasses, 50% is required on the order date and the remaining balance is due on the pick-up date. On contact lens orders, payment is required in full at time of pick-up.

PATIENT'S NAME: _____

SIGNATURE: _____ DATE: _____

GUARDIAN SIGNATURE (if patient is under 18)

_____

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# ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

The law requires that Jarvis Vision Center, PLLC make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

☐ I have read or had explained to me Jarvis Vision Center, PLLC's Notice of Privacy Practice and agree to continue my care with Jarvis Vision Center, PLLC under said terms.

☐ I authorize Jarvis Vision Center, PLLC to release my personal health information to the following individuals:

Name _____ Relationship to Patient _____

Name _____ Relationship to Patient _____

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

_____
Patient Name (Printed)

_____ _____
Patient/Parent/Guardian Signature Date

If you are signing as a personal representative of the patient, please indicate your relationship.

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# REQUEST FOR LIST OF PRESCRIPTIONS

*Private and Confidential*

In order to check for drug allergies or interactions, we are required to obtain an official list of your medications from your primary care provider and perform a Medication Reconciliation.

Please provide the following information about your provider and sign the release below. We will contact your provider and request a confidential electronic record be sent to our office via fax or secure direct email.

Primary Care Provider: _____

Office: _____

Doctor: _____

Fax #: _____

☐ I authorize the primary care physician listed above to release medication information to Jarvis Vision Center. Please send a copy of my **Summary of Care Record**, showing my **Active Medication List** to Jarvis Vision Center.

- Fax: (270) 759-1493
- Secure Email:
  - Dr. Jarvis rjarvis@direct.revolutionehr.com
  - Dr. Williams jesse.williams@direct.revolutionehr.com

☐ I do not have a primary care provider.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

Patient Full Name _____ Date of Birth _____

Patient Signature _____ Date Signed _____

Guardian or Personal Representative _____ Relationship to Patient _____

Guardian or Personal Representative _____ Date Signed _____

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**To be completed by Primary Care Provider. Please Indicate One:**

☐ Summary of Care record with active medication list is attached

☐ No active prescriptions on file