

Welcome to Jarvis Vision Center!

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



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						



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 I may request to receive a hard copy of my contact lens prescription or I may access it through my patient portal at www.revolutionphr.com.

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) _____



**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.

- The Notice of Privacy Practice could not be read due to the emergent nature of the care of other reason described as

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

_____ Name	_____ Relationship to Patient
_____ 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 _____.



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

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