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.

Missed or Broken Appointments:

Unless cancelled or rescheduled within 1 (one) BUSINESS DAY to the appointment time, your account will be charged $50 for each missed appointment. To book you next appointment these fees are to be paid in full. This is not something we want to do; however, it has become necessary. If there has been a total of 3 or more same day cancellations or broken appointments, we will require a $50 deposit to hold your appointment time. (If this appointment is kept, the deposit will be applied to your balance that day or refunded.) Every effort will be made by our office to see you at the scheduled appointment time. If you arrive more than 15 minutes late for a scheduled appointment, you may be asked to reschedule. We do not want to encroach upon someone else's time or have you rushed through 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 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 "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 _____.

JARVIS
VISION CENTER

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