The Vision Store

WELCOME TO OUR OFFICE

Our Mission

We Are Dedicated To Providing Our Patients With The Highest Quality Eye Care And Service Possible. We Will Seek Continuing Education To Remain At The Forefront Of Our Profession And Will Offer The Latest Eye Care Technology And Products. We Are Committed To Delivering This Care With Honesty And Compassion To Better Serve You And Your Family.

Please Complete ALL Sections

Patient Information

Today's Date_____
Last _____
First _____MI _____
Street _____
City _____ State _____
Zip Code _____
Phone Home _____ Cell _____
Work Phone _____
Patient's SSN _____
Date of Birth _____Age _____
Sex M F
Email Address _____
Employer (or School) _____
Driver's License _____State_____
Occupation (or Grade) _____
Guarantor (or Parent's Name) _____
Guarantor (Employer) _____
Guarantor's Address_____
City_____State_____Zip_____
Sex_____ DOB _____ SSN _____
What is the purpose of this visit? Are you experiencing any problems with your current contact lenses or eyeglasses?_____
_____
_____ ☐CC

Insurance Information

Vision Insurance_____
Relation to Subscriber_____
Subscriber SSN _____
Subscriber Birth Date _____
Insurance ID_____
Policy Group #_____

Primary Medical Insurance _____
Subscriber Name _____
Subscriber SSN _____
Subscriber Birth Date _____
Insurance ID _____
Policy Group # _____
How will you settle your account today?
☐ Cash ☐ Check ☐ Credit Card

Lifestyle Questions

Do you…… (Check box if your answer is yes)
❑..Work at a computer? Hrs. /Day___cell phone___
flat screen tv___ tablet/I pad_____
❑..Think you might benefit from thinner, lighter lenses?
❑..Have interest in a "test drive" of the latest contact lens designs
❑..Spend time outdoors? How much? _____Hrs/week
❑..Have polarized prescription sun wear?
❑..Prefer not to wear your glasses at times?
❑..Want information on Laser Vision Correction surgery?
❑..Have more than 1 pair of current Rx eyewear?
❑..Have children?
❑..Have family members in need of eye care?
❑..What do you do for fun?

WHO MAY WE THANK FOR REFERRING YOU?
__Yellow Pages __Social media __Internet / website
__Walk in __Drive by __Insurance
*__Family/Friend Name:*_____

Do you experience or have you been diagnosed or treated for any of the following?

❑ Blurry Vision	❑ Iritis/Uveitis
❑ Cataracts	❑ Corneal Abrasion
❑ Crossed eye/Eye turn	❑ Double Vision
❑ Eye Infections	❑ Eye Injury
❑ Flash of light	❑ Tearing
❑ Glaucoma	❑ Grittiness
❑ Headaches	❑ Burning
❑ Lazy Eye	❑ Itchiness/Allergies
❑ Macular Degeneration	❑ Dry Eyes
❑ Retinal Detachment	❑ Sunlight Sensitivity
❑ Floaters	❑ Trouble seeing at night
❑ Uncomfortable glasses	

❑ other eye disorders_____☐CC

Patient Eye History

Date of Last Eye Exam: _____
By Whom? _____
Please note that some insurance do NOT cover the Contact Lens Fitting Evaluation.
Are you interested in contact lenses? ☐ Yes ☐ No
Do you currently wear contact lenses? ☐ Yes ☐ No
What brand of Contacts? _____
Solution used?_____
Are you satisfied with the vision and comfort of your contact lenses? ☐ Yes ☐ No
Would you prefer clear contact lenses or colored contact lenses? ☐ Clear ☐ Colored
If you wear bifocals? Do the lines or head tilting bother you?
☐ Yes ☐ No
☐CC

The information in this confidential case history form is critical to the evaluation of your vision health exam.

Patient Medical History

Name of Family Physician_____ ☐ RFV
Town_____
Date of Last Physical Check-up_____
CURRENT MEDICATIONS (Rx or Over the Counter)
(List name of medications including eye drops, vitamins, & birth control pills)
☐PH
_____
_____

Are you allergic to any medications? ☐ Yes ☐ No
If so, which medications?
_____
_____

Have you had any surgeries? ☐ Yes ☐ No
Please List _____

Do you use cigarettes/tobacco, alcohol, or other substances?
☐**Yes** ☐ **No** ☐ PH

Are you Pregnant? ☐ **No** ☐ **Yes Months?** _____

Have you ever been diagnosed or treated for any of following health problems?
(Check all that apply to you. Y –yes N- no)

Constitutional
_Developmental disability
_Weight Loss
_Fever
_Fatigue
_Migraines
_Excessive Headaches
Skin/Integumentary
_Eczema
_Skin Cancer
_Psoriasis
Cardiovascular
_Heart Disease
_Stroke
_Vascular Disease
_Hypertension
Respiratory
_Asthma
_Bronchitis
_Emphysema
Neurological
_Multiple Sclerosis
_Epilepsy
Endocrine
_Diabetes
_Thyroid Problems
Ears/Nose/Throat
_Hearing Problems
_Upper Respiratory tract infection

Gastrointestinal
_Ulcer
_Colitis
_Digestive Disorder
Genitourinary
_Urinary Tract infections
_Kidney Problems
_STD
Musculoskeletal
_Fibromyalgia
_Osteoarthritis
_Muscular Dystrophy
_Arthritis
Psychiatric
_Depression
_Panic Disorder
_Schizophrenia
Hematologic/Lymphatic
_Anemia
_Leukemia
_Clotting Disorder
Allergic/Immunologic
_Drug Allergy
_Hay Fever
_Lupus
_ Aids

Other: _____

☐ PH/ROS

Family Medical/Eye History (Check all that apply)

Is there a family medical history of any of the following? ☐ PH
(Please indicate relationship and Mother or Father's side.)

Blindness ❑_____
Cataracts ❑_____
Corneal Problems ❑_____
Diabetes ❑_____
Glaucoma ❑_____
Heart Disease ❑_____
Lazy Eye ❑_____
Macular Degeneration ❑_____
Retinal Problems ❑_____

- A contact lens prescription is not the same as a prescription for glasses. Contact lenses are considered Class III Medical Devices by the FDA, which means that they require the highest degree of control due to the potential for complications. Contact lenses cannot be dispensed without additional measurements and evaluation of the lenses on the eyes. The fees for contact lens treatment and medical management are not covered under a routine eye examination. Contact lens exams are highly recommended on an annual basis. The contact lens prescription is good for one year due to valid clinical reasons of maintaining good ocular health and potential prescription changes. Dr Casaus follows the American Optometric Association guidelines for all areas of eye care including contact lenses. It is imperative that you adhere to the wearing schedule and solution regimen prescribed by Dr. Casaus. Once a contact lens prescription is finalized, it is available for a specified number of refills at the Dr's discretion. All associated fees must be paid prior to the dispensing of contact lenses and/or contact lens prescription release. We do not guarantee that every patient who wants to wear contact lenses will be successful with them. If a patient tries contact lenses and decides not to proceed with them, they are not required to purchase contact lenses. The contact lens treatment and medical management fees are non-refundable.
- The treatment recommended by our office is never based on what your insurance company will pay but what your specific needs are. Your treatment should not be governed by your insurance contract.

However, it should be understood, that the insurance contract is between the insurance company and the patient, who bears the ultimate financial responsibility. If the insurance company fails to pay **within 60 days** after claim submission, the balance due will be transferred to the patient or guarantor.

Patient portion, including **Contact Lens Fitting** and **Copays**, are due the same day treatment is rendered. Professional fees are nonrefundable.

This is an agreement in which you, the patient or legal guardian, agree to pay for professional services and ophthalmic products, rendered by Dr. Deidra M. Casaus and The Vision Store.

It is agreed that if in the event of legal proceeding to collect any part of fees due, the patient or legal guardian agrees to pay additional sum including attorney fees and collection costs.

- ***I have read and understand the notice of Privacy disclosed in the HIPPA Form and the information stated above.***

Signature _____Date _____

The Vision Store