PERSONAL INFORMATION (PLEASE PRINT & USE BLACK INK)

NAME: ____

ADDRESS: ____
Street City State Zip Code

PHONE: (HOME): ____________________(CELL) ___________________(WORK): _____________________

OTHER PHONE: ____________________ EMAIL: ____

DATE OF BIRTH: ___________ AGE: _____ M/F SOCIAL SECURITY # ____________________

MARITAL STATUS: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

EMPLOYER: _________________________________ CONTACT PERSON: ______________________

ADDRESS: ____
Street City State Zip Code

Primary Language**:** ______________________________

Family Doctor: _________________________________ Phone: _______________________________

Pharmacy: ____________________________ Address: _____________________________________

Spouse's Name: ______________________________________ Date of birth: _________________

Social Security Number: ___________________________________

Who referred you? _________________________________ Phone: _____________________________
(O.D., M.D., Friend, Other)

Who should we notify in case of an emergency (nearest relative or friend)?

Name: ____ Relationship: __________________________

Address: ____ Phone: _______________________________

Is someone involved in your care (such as a spouse, child, nurse, or friend) **who you want** to have access to your medical information? **YES** ____ **NO** ____**.** If yes, that person or persons must be listed below, along with one identifying piece of information to verify the person's identity if they contact us (such as date of birth):

Name: _________________________ Relation: _____________ DOB: ________ Phone: __________________

Name: _________________________ Relation: _____________ DOB: ________ Phone: __________________

I have been given the opportunity to review Natural Vision®'s **Notice of Privacy Practices.**

Signature (**Patient** or parent, if minor): ________________________________ Date: ______________

Please Complete Page 2 (over)

Complete this top portion if patient is less than 18 years old:

Name of Father: ________________________________ Employer: ____________________________

Address: ______________________________________ Work # _______________________________

Date of Birth: ___________________________________ Social Security # _____________________

Name of Mother: ________________________________ Employer: ____________________________

Address: ______________________________________ Work # _______________________________

Date of Birth: ___________________________________ Social Security # _____________________

FINANCIAL ASSIGNMENT AND AGREEMENT:

1. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge**. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by insurance**.
2. In order to control your cost of billings, we request that your charges for office visits be paid at the conclusion of each visit, unless you are covered by Medicare.
3. I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information about me to be released to the Health Care Financing Administration, its agents, or any insurance carrier I may have, or any information needed to determine these benefits or the benefits payable for related services.
4. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. **I understand that I am financially responsible for all charges whether or not paid by my insurance.** I hereby authorize said assignee to release all information necessary to secure payment.
5. **Payment Acceptance Policy/Returned Check Policy**
   Payment Acceptance
   a) Natural Vision gladly accepts cash, debit/credit cards, and checks for payment when presented with photo identification under the following conditions:
      i. All personal checks must have a physical address
      ii. Natural Vision does not accept counter checks/starter checks
      iii. Natural Vision does not accept credit card account checks
   b) All checks must be presented with the following items:
      i. Driver's license or government issued ID from the individual
      ii. Phone number (work or home)

   Returned Check Policy
   a) If a check is returned by your financial institution for any reason, your account at Natural Vision will be assessed $35 ($25 Returned Check Fee plus $10 Bank Service Charge). Natural Vision will not accept checks from anyone who has previously presented a check that was returned for any reason.
   b) Checks returned for any reason and not paid in full within 15 days of notification will be submitted to the Fresno/Madera County District Attorney's Office Bad Check Restitution Program.

Signature (**Patient** or parent, if minor): ____________________________ Date: _________________

PLEASE PROVIDE US COPIES OF YOUR INSURANCE CARDS & PHOTO ID

Natural Vision™
A MEDICAL GROUP

EYE HISTORY

(Please Print & Use Black Ink)

Name: ____ Date: _____________________

Thank you for choosing Natural Vision™ for your eye care. To better serve you, please answer the following questions:

1. Do you wear glasses? ☐ Yes ☐ No
2. Do you wear contact lenses? ☐ Yes ☐ No
3. Do you have problems reading? ☐ Yes ☐ No
4. Are you currently experiencing any eye symptoms? Please check all that apply:

   ☐ Eye pain ☐ Blurred Vision ☐ Eyelid Crusting ☐ Flashes of Light ☐ Halos

   ☐ Discharge ☐ Light Sensitivity ☐ Double Vision ☐ Decreased Vision ☐ Floaters

5. Have you ever had an eye injury? Please describe:

____

____

6. Have you ever had eye surgery? Please list type, which eye and approximate dates:

_________________________________ R/L __________________________________

_________________________________ R/L __________________________________

7. Are you currently using any eye medication? Please list name and how often used:

____

____

8. Are you being treated for any medical conditions? Please check all that apply:

   ☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Cholesterol

   ☐ Stroke ☐ Arthritis ☐ Other: ______________________

9. Are you positive for HIV or any form of Hepatitis? ☐ Yes ☐ No
10. What medications other than above are you taking? Please list:

____

11. Are you allergic to any medications? Please list:

____

12. Do you have any family history of eye problems? Please check and list family relationship:

☐ Glaucoma ______ ☐ Cataract ______ ☐ Retinal Disease ______ ☐ Macular Degeneration _____

13. Do you smoke? ☐ Yes ☐ No. If so, for how long: ___________ How much:____________