PRECISION **VISION**|482 S. Main Street, Spanish Fork, UT 84660|801-504-6448

Welcome to Our Office

Patient Name: _____

Male / Female Married / Single Prefix: Mr / Mrs / Ms / Dr

Street Address: _____
City: _____ State: _____ Zip: _____
Phone Number: _____ (Cell/Home)
Secondary Number: _____ (Cell/Home)
Email Address: _____
I would like to receive updates by:
□ Phone □Text □Email
Date of Birth: _____ Age: _____
Social Security #: _____
How did you hear about Precision Vision:
_____
Hobbies: _____
Employer: _____

Primary Health Insurance:_____
Member ID:_____
Primary Policy Holder Name:_____
DOB:_____ SS#:_____
Vision Insurance Name: _____
Member ID: _____
Primary Policy Holder Name: _____
Date of Birth: _____ SS#: _____
Patient Relationship to Insured: (Circle one)
Self Spouse Child Other

Financial Policy:

-Insurance verification is not a guarantee of payment. Copies of insurance cards, name, and birth date of insurance subscriber for each family member at each visit are necessary for accurate and timely insurance billing.

-I hereby authorize Precision Vision, or their designee(s) to exchange information regarding my care and benefits with the above listed insurance company or companies for the purpose of collecting professional fees on my behalf.

-I understand that I am financially responsible, including all deductibles, for charges of Precision Vision that are not paid by my insurance and/or Medicare. All medical care is due and payable upon completion unless prior arrangements have been specified.

-The patient will be charged any processing fee plus $15 for any declined or rejected check/payment.

I have reviewed and accept Precision Vision's HIPPA Privacy Policy and Financial Policy:

Signature: _____

Date: _____

Eye History:
□ Blurry Vision Date/Year: _____
□ Glasses Date/Year: _____
□ Contacts Date/Year: _____
□ Cataracts Date/Year: _____
□ Glaucoma Date/Year: _____
□ Macular Degeneration Date/Year: _____
□ Other: _____ Date/Year: _____

Medical History:
□ Diabetes □ Arthritis □ Heart Disease □Asthma
□ High Blood Pressure □ High Cholesterol
□ Currently Pregnant or Nursing □ Other: _____

Family History of Eye Disease & Relationship *(father, mother, sister, brother, etc.):*
□ Glaucoma _____
□ Macular Degeneration: _____
□ Other _____

Drug Allergies:
_____

Current Medications: (List additional medications on back.)
(*Drug name/Dose/Strength/How it's taken)*
_____
_____
_____

Primary Care Doctor:_____

Review of Systems:
(Check yes if you have any of the following? If so, specify the issue)

Yes	No	
□	□	Skin: itching, rash, swelling, etc.
□	□	Blood & Lymphatic: swelling, tenderness, bruise easily, prolonged bleeding, etc.
□	□	Musculoskeletal: pain, swelling, etc.
□	□	Endocrine: fatigue, confusion, fainting, etc.
□	□	Allergy/Immunology: hay fever, hives, seasonal
□	□	Ears, Nose, Throat: _____
□	□	Neck: pain, stiffness, etc.
□	□	Respiratory: cough, asthma, etc.
□	□	Cardiovascular: chest pain, swelling limbs, etc.
□	□	Gastrointestinal: nausea, vomiting, diarrhea, etc.
□	□	Genitourinary: frequency, burning, pain, etc.
□	□	Neurological: weakness, numbness, etc.
□	□	Psychiatric: anxiety, depression, etc.

Other issues not listed above: _____
_____

Please review the information above every following year and then initial and date below.

_____|_____|_____|_____|_____|_____|_____