Dr. Terence G. Templeton / Pro-Vision, Inc.
Welcome To Our Office

Date:______________________________________

☐ Mrs. ☐ Ms ☐ Miss ☐ Mr. ☐ Dr ☐Master (child)

Last: ______________________________________

First:__________________________ MI _________

Preferred Name:_____________________________

Street:___________________ City:______________

State:____________________ Zip: ______________

Birth Date: _______________ Age: ______________

☐ Married ☐ Single ☐ Widow/er ☐ Divorced
☐ Employed ☐ Retired ☐ Student

Employer: __________________________________

Occupation:_________________________________

Social Security #:_____________________________

Home Phone: _______________________________

Cell Phone:__________________________________

Work Phone:_______________ Ext:_____________

Preferred Phone ☐ Home ☐ Work ☐ Cell

Email:______________________________________

What is the major purpose of this visit?

____

Does your insurance require that you have a **referral** or **pre-authorization** to see a specialist? ☐ Yes ☐ No

Any **problems** with your current contact lenses or glasses? _______________________________

Does responsible party participate in a **flexible spending account**? ☐ Yes ☐ No

Insurance Information

Please note that insurance does **NOT** cover the contact lens follow up evaluation.

Please give the receptionist your **medical** (health) insurance and **vision** insurance cards.

Your insurance company makes the **final** decision on payment. We will try to **estimate** your insurance coverage. Depending on how your insurance company decides, you **may owe** more money than we have estimated for you.

Lifestyle Questions

Do you… (please check all that apply)

☐ Work at a computer?
☐ Think you might benefit from a thinner lens?
☐ Have interest in a "test drive" of the latest contact lens designs?
☐ Have prescription sun wear?
☐ Prefer not to wear your glasses at times?
☐ Want information on Laser Vision surgery?
☐ Have more than 1 pair of current Rx eyewear?
☐ Have children in need of eye care?
☐ Have family members in need of eye care?

Have you ever been diagnosed, or treated for any of the following?	**Have you recently experienced any of the following?**
☐ Cataracts	☐ Blurry vision
☐ Crossed eye/Eye turn	☐ Flashes of light
☐ Eye infections	☐ Headaches
☐ Glaucoma	☐ Itchiness
☐ Macular Degeneration	☐ Tearing
☐ Retinal detachment	☐ Burning
☐ Corneal abrasions	☐ Double vision
☐ Eye injury	☐ Floaters/spots
☐ Irisis/Uveitis	☐ Grittiness
☐ Lazy eye	☐ Occasional dryness
☐ None of these	☐ Sunlight sensitivity
	☐ Trouble seeing at night
	☐ None of these

☐ Other__________________________________

PRIVACY POLICY: I understand that my vision/medical records are confidential. I understand that by signing this consent form, I am allowing my vision/medical information to be released to my insurance company only for the purpose of Health Care Operations, including, but not limited to, provider review functions, claims payment and quality assessment. I also understand that I may revoke this consent by written request at any time with Dr. Templeton and Pro-Vision. If revoked, it is understood by all parties that all information released prior to being notified of such revocation was made with my consent. I understand that I have the right to restrict the disclosure of specific information in my medical records if I request such restriction in writing. I also understand that my request for restriction may be denied if the information restricted is required for Health Care operations.

Please initial and date______________________
(for above **HIPPA** privacy notice)

Our team at Pro-Vision is dedicated to meeting your needs with fashionable, high quality eyewear and professional eye care to enhance the quality of your life.

Patient Medical History

Name of family physician_____________________
City_____________________
Date last physical checkup_____________________

Current medications (Rx and over the counter)
(Include eye drops, vitamins, birth control, medications)

____
____
____

☐ **Receptionist has copied list of medications**

Allergies to medications? ☐ Yes ☐ No
List: _____________________
____
____
____

Have you had any recent surgeries ☐ Yes ☐ No
Do you use cigarettes/tobacco, alcohol or other substances? ☐ Yes ☐ No

Have you ever been diagnosed or treated for the following health problems?

	Yes	No
Allergies	☐	☐
Arthritis	☐	☐
Asthma	☐	☐
Blood/lymph	☐	☐
Bronchitis	☐	☐
Cancer	☐	☐
Cholesterol	☐	☐
Diabetes	☐	☐
Digestive	☐	☐
Ears/Nose/Throat	☐	☐
Endocrine	☐	☐
Eczema/Rashes	☐	☐
Fatigue	☐	☐
Fevers	☐	☐
Genitourinary	☐	☐
Heart	☐	☐
High blood pressure	☐	☐
Integumentary (skin)	☐	☐
Kidney	☐	☐
Muscle/bone	☐	☐
Neurological	☐	☐
Psychological	☐	☐
Respiratory (breathing)	☐	☐
Sinus	☐	☐
Throat infections	☐	☐
Thyroid	☐	☐
Unusual weight loss/gain	☐	☐

Patient Eye History

If new patient, date of last eye exam and by whom
____

Have you ever tried contact lenses? ☐ Yes ☐ No

Do you currently wear contacts lenses? ☐ Yes ☐ No
What kind?_____________________
Solutions used:_____________________
Are you satisfied with the vision and comfort of your contact lenses? ☐ Yes ☐ No

Family Medical / Eye History

	Relationship to patient
☐ Blindness	________
☐ Cataracts	________
☐ Corneal Problems	________
☐ Diabetes	________
☐ Glaucoma	________
☐ Heart Disease	________
☐ Lazy Eye	________
☐ Macular Degeneration	________
☐ Retinal problems	________
☐ None	

Please Read Carefully

Please be advised if you are using insurance coverage for today's visit, this is a **contract between you and your insurance company**…NOT Pro-Vision, Inc. or Dr. Templeton. **Any amount not covered by insurance is the patient's or guardian's responsibility**

If your insurance company has not reimbursed our office in full within 90 days, the balance will then be your responsibility and due within 10 days of receipt of your statement. If your insurance company pays after the 90 day period, we will then forward the check to you.

We do not file Secondary Insurance, however, we will give you an itemized receipt with all codes required by the insurance company.

Financial Policy: The **doctor's fees are due today** and a **deposit of 50%** is due on all orders. The balance is **due at the time of delivery**. There is a **$25 fee** for all returned checks. All unpaid balances over 60 days will be assessed a **$50 collections fee** and turned over to collections.

Signature:_____________________

Date:_____________________