CLEAR CHOICE
vision care

Please make sure to mark every line and box. If the question does not apply to you, write "N/A".
This extensive history form is required due to the new insurance regulations. If you need help with this form, please ask the receptionist or your doctor.

First Name _____ Last Name _____ M.I. _____ Date of Birth _____ **Sex**: Male ☐ Female ☐

Address _____ City _____ State TN Zip Code _____ Employer _____ ☐ N/A

Primary Phone Number _____ ☐ Mobile ☐ Home ☐ Work
Secondary Phone Number _____ ☐ Mobile ☐ Home ☐ Work
Email Address _____
Preferred method of contact
☐ Opt out of recalls/reminders

PLEASE MARK "YES" OR "NO" TO INDICATE IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING:

CONSTITUTION		CARDIOVASCULAR		MUSCLE/SKELETAL	
Sudden Weight Gain/Loss	☐ YES ☐ NO	Heart Pain	☐ YES ☐ NO	Rheumatoid Arthritis	☐ YES ☐ NO
Excess Fatigue	☐ YES ☐ NO	High Blood Pressure	☐ YES ☐ NO	Muscle or Joint Pain	☐ YES ☐ NO
EAR/NOSE/THROAT		High Cholesterol	☐ YES ☐ NO	**SKIN**	
Seasonal/Environ. Allergies	☐ YES ☐ NO	Heart Disease	☐ YES ☐ NO	Eczema/Rosacea	☐ YES ☐ NO
Sinus Congestion (chronic)	☐ YES ☐ NO	**IMMUNOLOGICAL**		Skin Cancer	☐ YES ☐ NO
NEUROLOGICAL		Autoimmune Disease	☐ YES ☐ NO	**OCULAR**	
Migraines	☐ YES ☐ NO	**ENDOCRINE**		Floaters/Lines in vision	☐ YES ☐ NO
Headaches	☐ YES ☐ NO	Diabetes	☐ YES ☐ NO	Flashes/Lightning streaks	☐ YES ☐ NO
Seizures	☐ YES ☐ NO	Thyroid Disease	☐ YES ☐ NO	Glare or Haloes around lights	☐ YES ☐ NO
RESPIRATORY		Increased Thirst or Hunger	☐ YES ☐ NO	**GASTROINTESTINAL**	
Asthma	☐ YES ☐ NO	**GENITOURINARY**		Stomach/GI Disorder	☐ YES ☐ NO
Bronchitis/Emphysema	☐ YES ☐ NO	Increased urinary frequency	☐ YES ☐ NO	**BLOOD/LYMPHATIC**	
COPD	☐ YES ☐ NO	**PSYCHIATRIC**		Anemia	☐ YES ☐ NO
Sleep Apnea	☐ YES ☐ NO	Anxiety or Depression	☐ YES ☐ NO	Bleeding Problems	☐ YES ☐ NO

PLEASE MARK "YES" OR "NO" TO INDICATE IF YOU OR A RELATIVE HAVE OR HAVE HAD ANY OF THE FOLLOWING:

CONDITION	YOURSELF	RELATIVE	RELATION
Lazy eye/Eye turn	☐ YES ☐ NO	☐ YES ☐ NO	_____
Retinal tear/Detachment	☐ YES ☐ NO	☐ YES ☐ NO	
Glaucoma	☐ YES ☐ NO	☐ YES ☐ NO	
Macular Degeneration	☐ YES ☐ NO	☐ YES ☐ NO	_____
Cancer	☐ YES ☐ NO	☐ YES ☐ NO	
High Blood Pressure		☐ YES ☐ NO	
Diabetes		☐ YES ☐ NO	_____

1) Please list any other ocular or medical history that ***you*** have, not already listed:
_____
_____
_____

2) Please list any other ocular or medical history that a ***relative*** may have, not already listed:
_____
_____
_____

PLEASE LIST ANY MEDICATIONS YOU TAKE: ☐ NONE

Medication	Dosage (if known)	Quantity	Please list means of administration if not in pill form	How long have you taken this medication?

Tobacco Use How often?
Alcohol Use How often?
Are you allergic to any medications? ☐ YES ☐ NO Please list: _____
Who is your Primary Care Physician? _____
Please list any major surgeries or accidents you have had: ☐ NONE _____
Please list any hobbies/sports/activities: ☐ NONE _____
Are you pregnant/nursing? ☐ YES ☐ NO **Are your immunizations up to date?** ☐ YES ☐ NO ☐ Unsure

Patient: By signing this form I attest that to the best of my ability the health information I entered to be correct and true.

Signature _____ Date _____

For office use ID _____
Opto ☐ Y ☐ N ☐ M
MI ☐ Y ☐ N Cp ____ Dedmet ☐ Y ☐ N

INFORMED CONSENT

Please read and sign all statements below that pertain to you/the patient

SIGNATURES REQUIRED FOR ALL PATIENTS

PRIVACY NOTICE: [This is a summary of the full policy displayed in our office.] It is required by law to maintain the privacy of your health information, to follow the terms of this notice, and to provide you with this notice of our legal duties and practices with respect to your health information. Clear Choice Vision Care may use/disclose your health information in the following ways: treatment; payment from insurance/third party groups, health care operations; to individuals involved in your care or payment for your care; as required by law to avert a serious threat to health or safety; for public health activities/risk prevention; health oversight activities; lawsuits/disputes; specialized government functions; workers compensation and similar programs; coroners/funeral directors; personal representatives. YOUR RIGHTS: You have the right to request special restrictions when using or disclosing health information,request/amend your medical information, and a copy of this notice. For any questions or to report a problem, call 615-826-1611. By signing this notice, I acknowledge that I have received, read and understand this Privacy Notice.

Signature _____ Date _____
Patient or Parent/Guardian

SIGNATURES REQUIRED FOR PATIENTS USING INSURANCE

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits to other third parties who accept assignment. I authorize payment to Clear Choice Vision Care/Kelli Johnson, O.D.

Signature _____ Date _____
Patient or Parent/Guardian

SIGNATURE REQUIRED FOR PATIENTS GETTING CONTACT LENSES

MUST BE OVER AGE 18 TO SIGN (or Parent/Guardian): Contact lenses are not without risk. A small portion of contact lens wearers develop potential serious complications leading to permanent vision loss. Unless told otherwise by your doctor, please follow these rules when wearing contact lenses: your contact lenses are daily, monthly, or biweekly disposable lenses and you agree not to sleep in your contact lenses; if you experience any pain, redness or discomfort, take your contact lenses out and return to our clinic or visit the ER immediately. Your contact lens fitting covers any follow-ups required to adjust the contact lenses for a period of three months following the initial visit. It does not cover any subsequent visits required to treat medical conditions incurred by contact lens wear. By signing this notice, I acknowledge that I understand this informed consent.

Signature _____ Date _____
Patient or Parent/Guardian

SIGNATURES REQUIRED FOR PATIENTS WITH DIABETES

Diabetes is a unique condition that can cause bleeding in the back of the eye and therefore is a *medical* condition. These examinations are not billed under your "routine vision care plans" such as Superior, Spectera, Davis, VSP, etc., however they are covered under your medical insurance. This examination for diabetes to rule out diabetic retinopathy is a more extensive examination requiring more documentation, regulation standards, and testing and therefore can cost more and is subject to your medical insurance deductibles and copays. You have the right to choose to use your routine vision plan to get your glasses or contact lens prescription or to use your medical plan. If you choose to use your routine plan Clear Choice Vision Care and its doctors encourage you to either return to our clinic or seek another provider to have your eyes properly checked for diabetic retinopathy. Some exceptions do apply.

☐ I elect to use my "medical plan" and ask that my doctor perform a diabetic eye health examination
☐ I elect to use my **"routine vision plan"** and will return at a later date to have my diabetic eye examination either here or with another provider

Signature _____ Date _____
Patient or Parent/Guardian