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*Our vision is to protect yours*

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Name: Last \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home / Mobile Phone: \_\_\_\_\_ Texting Okay? Y / N Work Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age \_\_\_\_\_ Male / Female SS#: \_\_\_\_\_

Marital Status:  Single  Married  Other \_\_\_\_\_ Race: Asian / Black / Hispanic / White / Other \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Email: \_\_\_\_\_

How were you referred to our office? \_\_\_\_\_

Who is the insurance policy holder?

Self  Other: Insured's Name: \_\_\_\_\_ Insured's DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Insurance information not required if you provided VISION and MEDICAL cards to receptionist

Name of Primary **Medical** Insurance Carrier: \_\_\_\_\_ ID # \_\_\_\_\_

Name of Secondary **Medical** Insurance Carrier: \_\_\_\_\_ ID # \_\_\_\_\_

Name of **Vision** Insurance Carrier: \_\_\_\_\_ ID # \_\_\_\_\_

✦ *If you have **diabetes**, your exam will be billed to your **medical** insurance. Every diabetic exam requires dilation and a report will be sent to your medical provider. Please note that the specialist copay is typically between \$30-\$60*

### Eye History

Why did you schedule your visit today? \_\_\_\_\_

Do you wear glasses? Yes / No / Full-time / Part-time / Distance Only / Near Only

Do you currently wear contacts? Yes / No / Clear / Color Brand \_\_\_\_\_

Do you want to be fitted for contacts today? Yes / No / Clear / Color

#### **Please check any of the following that apply**

- |  |  |                                     |   |
|--|--|-------------------------------------|---|
| <input type="checkbox"/> Blurry vision       | <input type="checkbox"/> Dryness or irritation | <input type="checkbox"/> Itchy Eyes | <input type="checkbox"/> Droopy Eyelid(s) |
| <input type="checkbox"/> Flashes or floaters | <input type="checkbox"/> Eye Pain or Redness   | <input type="checkbox"/> Headaches  | <input type="checkbox"/> Double Vision    |

#### **Medication changes since last eye exam**

**Please complete other side**

**Authorization for Release of Information**

This form authorizes Spartanburg Vision to release protected information about the patient to the people listed below (e.g. spouse, parent, sibling) by means of phone calls and voice mails/answering machine messages.

I consent to the release of (please check all that apply):

- Financial/Billing Information
- Medical Care (treatments plans, medications, procedures, appointments, test results, etc.)


\_\_\_\_\_ Name/Relationship to patient

\_\_\_\_\_ Phone

**Access to your Glasses and Contact Lens Prescriptions**

- In an effort to reduce paper waste, we request that you allow us to provide you with a digital copy of your prescriptions through our patient portal.
- In addition to 24/7 access through your patient portal, we are always happy to provide you with a printed copy of your prescription or, if you prefer, we can also send it to you via email.

I agree to receive a digital copy of my prescription via the patient portal     YES     NO

  
(Please Initial)


**Eyeglass Refund & Exchange Policy**

We want you to love your new glasses and are committed to making things right if there is an issue. Because prescription lenses are custom-made specifically for you and cannot be reused, full refunds are not available once lenses have been manufactured by the lab.

**Our Promise to You**

- If you are having difficulty adapting to your new lenses purchased at our office, we will gladly provide a **one-time remake at no charge within 30 days** of purchase. If you remain dissatisfied after the lenses have been remade:
  - Lenses may be returned for a 50% refund
  - Frames may be returned if they are in original condition. A \$20 re-stocking fee will be applied.
- If you are having difficulty adapting to lenses purchased elsewhere, ask the seller to verify that the lenses have been made correctly. If difficulty persists, we will be happy to re-check your prescription but this may incur a refraction fee.

Your satisfaction matters to us. If you are having trouble with your glasses, please let us know—we will make every reasonable effort to resolve the issue before considering a refund.

  
(Please Initial)

**Statement of Financial Responsibility and Assignment of Insurance Benefits**

I understand that I am financially responsible for all charges not paid by insurance. I authorize the release of information to my insurance company for billing purposes. I hereby authorize payment from my insurance company to Spartanburg Vision.

***We require that a retinal image is taken for every patient. The fee is \$10 and is not covered by insurance.***

**X** \_\_\_\_\_  
Signature of Patient (legal guardian if minor)

\_\_\_\_\_ Print Name

\_\_\_\_\_ Date