

Dr. Tom MacMillan
 Dr. Jeremy Anderson
 Dr. Lindsay Wood
 Dr. Alexis Mears
 Dr. Melissa Bogert



227 E. Blackstock Rd, Suite 200
 Spartanburg, SC 29301
 (864) 576-0564
 www.spartanburgvision.com

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

- | | | | Self | Family Member |
|--|--|-------------------------|--------------------------|--------------------------------|
| <input type="checkbox"/> Blurry vision | <input type="checkbox"/> Light Sensitivity | Cataracts | <input type="checkbox"/> | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Flashes or floaters | <input type="checkbox"/> Headaches | Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Eye Pain or Redness | <input type="checkbox"/> Double vision | Blindness | <input type="checkbox"/> | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Dryness or irritation | <input type="checkbox"/> Wandering Eye | Macular Degeneration | <input type="checkbox"/> | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Itchy Eyes | <input type="checkbox"/> Droopy eyelid(s) | Retinal tear/detachment | <input type="checkbox"/> | <input type="checkbox"/> _____ |
| | | Keratoconus | <input type="checkbox"/> | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Other: | | | | |

Please complete other side

Patient Name: _____

Date: ____ / ____ / ____

Name of Medical doctor: _____

Name of Medical Practice: _____

Medical History

Do you have, or have you been treated for, any of the following? (Check all that apply)

- | | | |
|--|--|---------------------------------------|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Asthma or COPD | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Migraine or Chronic Headaches | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Anxiety |

Medication Allergies: _____ Other Allergies: _____

Current medications: _____

Please list any major surgeries: _____

Tobacco Products: Never Smoked Former Smoker Current Smoker

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.)

This information may be released to the following:

- Patient's voice mail/answering machine
- Voice mail/answering machine of (e.g. spouse, parent sibling):

_____	_____
Name/Relationship to patient	Phone

_____	_____
Name/Relationship to patient	Phone

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed by sending a written notification to Spartanburg Vision. I understand that a revocation is not effective in cases where the information has already been disclosed.

(Please Initial)

Notice of Privacy Practices

Spartanburg Vision will provide me a copy of their Privacy Practices upon request.

(Please Initial)

