MARYSVILLE FAMILY VISION

Welcome to our office!

Dr. Shimul Y. Shah

Optometrist

Today's date: ______________________ Nickname ______________________

Full Name: ______________________ DOB: ______________________

Address: ______________________ Gender: ______________________

City/State/Zip: ______________________ Spouse/Parent: ______________________

Home Phone: ______________________ Previous Optometrist: ______________________

Cell Phone: ______________________ Last Exam: ______________________

Work Phone: ______________________ Family Doctor ______________________

Email Address ______________________

*******INSURANCE INFORMATION FOR THE PERSON WHO CARRIES THE INSURANCE*******

If you have insurance, we will gladly process your claim but we request that you pay your estimated portion, including copays, at the time of service. If you realize more than 2 weeks after the date of your appointment that you have insurance we will be unable to back date the claim. We require a complete payment of any glasses or contacts at the time of ordering.

***Subscriber's Name:** ______________________

***Subscriber's SS#:** ______________________ ***Subscriber's DOB:** ______________________

PLEASE PRESENT YOUR INSURANCE CARD SO WE CAN MAKE A COPY. THANK YOU!!

(check one)	Personal	Family
Allergies		
Arthritis		
Asthma		
Cancer		
Diabetes		
Heart Disease		
High B. Pressure		
Kidney Disease		
Cholesterol		
Thyroid		
Glaucoma		
Cataracts		
Blindness		
Macular Deg.		
Eye Turn		

History of Eye Injury? Y N

What/When? ______________________

History of Eye Surgery? Y N

What/When? ______________________

Please list all meds: (inc. dosage) ______________________

____

____

____

Please list all allergies: ______________________

____

How did you hear about our office?

_____ Previous Dr. Shoemaker Patient

_____ Referred by family/friend? ______________________

_____ Referred by another doctor

_____ Yellow pages

_____ Previous Dr. Shah patient in Powell/Dublin

_____ Office Signage

_____ Facebook/Social Media/Google Search

_____ Local Advertisement- which? ______________________

_____ Insurance/Website

_____ **I acknowledge that I have been offerred a copy/read the presented Privacy Practices from Marysville Family Vision. (sign and date below)**

____

Do you experience any of the following?

_______ Blurry distance vision	_______ Nausea	_______ Headaches
_______ Blurry computer vision	_______ Floaters in vision	_______ Gritty feeling
_______ Blurry near vision	_______ Sensitivity to light	_______ Redness
_______ Burning	_______ Sudden loss of vision	_______ Tearing
_______ Double vision	_______ Glare at night	_______ Dryness
_______ Glare on computer	_______ Dizziness	_______ Watering
_______ Itchiness	_______ Flashes of light	

What is the major purpose of this visit?

____

What do you like about your current glasses or contacts?

____

____

What do you dislike about your current glasses or contacts?

____

____

Have you ever worn contact lenses? Y N

How long ago? _______________ What kind? _______________

Are you interested in trying or discussing contacts? Y N

Do you work on a computer for extended hours?? Y N Hours/day _______

Do you spend a lot of time outdooors? Y N

Do you have 100% UV blocking sunglasses? Y N

Are you interested in discussing surgical vision correction? Y N

I authorize the release of any medical information necessary for Marysville Family Vision to process all insurance claims, at any time, for medical services rendered. I request payment of all claims to be paid directly to Marysville Family Vision unless payment has already been rendered by me. I understand that I am responsible for for any amount not covered by my insurance.

If I am ever to fill a prescription (contacts or glasses) obtained from another office, I understand that Marysville Family Vision is not responsible for any remakes or reorders if that prescription is incorrect. We will, however, guaranty the lenses themselves and assume responsibility for the quality and accuracy of the lenses to the prescription that was presented to us.

____

Signature Date