Personal Information

Last name:_____ First Name:_____ MI_____
Address:_____ City:_____ State:_____ Zip:_____
Home Ph# _____ Wrk Ph# _____ Member ID #_____
DOB:_____ Occupation:_____ Employer:_____
Emergency Contact Name:_____ Phone Number:_____
Date of Last Eye Exam:_____ Dilated? Yes/No
Today's Date:_____ Referred By:_____

Medical Information

What is your general health?_____
Do you have any of these problems? **(Please circle yes or no.)**

Gastrointestinal	Yes/No	Nervous	Yes/No	Endocrine (glands)	Yes/No
Ears/Nose/Throat	Yes/No	Urinary	Yes/No	Blood/Lymph	Yes/No
Cardiovascular	Yes/No	Muscles/Bones	Yes/No	Allergic/Immunologic	Yes/No
Respiratory	Yes/No	Skin	Yes/No	Headaches	Yes/No
High Blood Pressure	Yes/No	Eyes	Yes/No	Mental	Yes/No

Please explain:_____
Diabetes Yes/No Type:_____ Date of Diagnosis:_____
Allergies to Medication? Yes/No Which?_____ Reactions:_____
Other health problems:_____
Current medication(s):_____ Check if none
Have you had any operations? Yes/No What kind?_____ When?_____
Name of Family doctor:_____ Phone Number:_____
Reason for Visit: Glasses? Yes/No Contacts? Yes/No Previous Wearer? Yes/No What Brand?_____

(continued on back)

(continued)

Family History

High Blood Pressure	Yes/No	Relation_____	Macular Degeneration	Yes/No	Relation_____
Diabetes	Yes/No	Relation_____	Retinal Detachment	Yes/No	Relation_____
Glaucoma	Yes/No	Relation_____	Cataracts	Yes/No	Relation_____

Personal Eye Information

Do you have any eye conditions or problems? Yes/No What kind?_____
Have you had any eye operations? Yes/No Type_____ Date:_____
Have you had an eye injury? Yes/No Kind_____ Date:_____

Do you have glaucoma?	Yes/No	Cataracts?	Yes/No	Dry Eyes?	Yes/No
Macular Degeneration?	Yes/No	Retinal Detachment?	Yes/No	Blurred Vision?	Yes/No
Do you wear Glasses?	Yes/No	Contact Lenses?	Yes/No	Type_____	

Additional Information_____

This questionnaire is to be reviewed at each appointment. Please review all Questions.

Reviewed Date_____ Changes: Yes/No
Reviewed Date_____ Changes: Yes/No
Reviewed Date_____ Changes: Yes/No
Reviewed Date_____ Changes: Yes/No

Doctor Use Only

Reviewed Date_____ Changes: Yes/No
Reviewed Date_____ Changes: Yes/No
Reviewed Date_____ Changes: Yes/No
Reviewed Date_____ _____ Changes: Yes/No

ls/10/04

CONSENT FOR RELEASE OF INFORMATION AND RESPONSIBILITY FOR PAYMENT

I consent to the use and disclosure by the Office any information, e.g. health information concerning my vision examinations and products, to any party and/or agent, including, but not limited to my employer, health plan or plan sponsor ("Plan"), as needed for my treatment, the payment of my vision benefit claims, and related customer communications regarding health care services provided by the Office (e.g. mailings of exam reminder/recall cards or explanations of services/products provided by the Office).

If I desire to seek third party reimbursement for the services received, I authorize the Office to submit a vision benefit claim for payment to any third party as identified. I understand that I am responsible for all charges incurred, including any portion not paid by any third party.

I understand that this consent for release of information is voluntary and I may revoke my consent at any time by notifying the Office in writing, except for any disclosure already taken in reliance of my consent to release of information. I understand that I may request the Office to restrict the use and disclosure of my information; however, the Office is not required to agree to my request.

Signature of Patient or Legal Representative _____ Date _____

Legal Representative's Relationship _____

1100 Michigan Ave.
Marysville, MI 48040

Ph: (810) 364-1334
Fax: (810) 364-1075

Total Vision Center

ACKNOWLEDGEMENT OF HIPAA PRACTICES

I acknowledge that I have been offered a copy of Thomas Woytta, O.D. Notice of Privacy Practices.

Patient Name: _____

Signature: _____ Date: _____