



Vision Benefit Maximizer

Thank you for choosing Crown Vision Center. In order to allow us to maximize your vision benefits, please fill out this form as completely as possible.

Patient Name: _____

Appointment: _____

Date of Birth _____	Age _____	Social Security Number _____
Home phone _____	Home address _____	
Mobile phone _____		
Work phone _____		
Email address _____	Gender _____	
Employer _____	Occupation _____	
Primary Vision Insurance		Secondary Vision Insurance
Name of Insurance _____		Name of Insurance _____
Policy Holder Name _____		Policy Holder Name _____
Policy Number _____		Policy Number _____
Group Number _____		Group Number _____
Primary Medical Insurance		Secondary Medical Insurance
Name of Insurance _____		Name of Insurance _____
Policy Holder Name _____		Policy Holder Name _____
Policy Number _____		Policy Number _____
Group Number _____		Group Number _____
Policy Holder Information (If you are covered under the policy of a spouse, partner, parent or guardian, please tell us about them)		
Policy Holder name _____		Relationship to Patient _____
Date of Birth _____		Social Security Number _____
Home phone _____		Home address _____
Mobile phone _____		
Work phone _____		
Employer _____		

Many eye diseases begin in your side, or peripheral, vision. A standard eye examination tests your central vision, which comprises only about 15% of your visual field. As such, a routine exam may not detect diseases early enough to prevent permanent vision loss. A visual field test evaluates the remaining 85% and may alert us to the presence of potentially vision threatening diseases, such as Glaucoma, tumors, neurologist diseases, and retinal detachment. This test can also detect certain systematic diseases such as hypertension, lupus, and diabetes, all of which can also lead to vision loss.

There is an additional fee for this test. YES, I DO want the visual field test

The HIPAA Policy was available to read during my office visit. _____ (Patient Initials)

Our office will file all vision claims if we are a participating provider for your plan. However, if your insurance denies payment for any claims submitted, you will be responsible for full payment. Otherwise, we will supply you with an itemized statement which you may submit to your insurance carrier. Full payment is required at the time of service.

Please check your method of payment. Cash Check Credit Card

I have read and understand the Statement of Financial Responsibility.

Signature of Patient (or Guardian) _____ **Date** _____

Signature of Physician _____ **Date** _____

Patient Medical information

Many medical conditions and medications affect the eyes. Please help the doctor by filling out your medical history as completely as possible. Please check all of the conditions that apply to you:
Have you had any eye injuries, eye surgeries, eye diseases, floaters or flashes of light? _____

Breathing Problem Yes No

___ Asthma

___ Emphysema

Skin Condition Yes No

___ Eczema

___ Rosacea

Endocrine Disorder Yes No

___ Diabetes

___ Thyroid Disorder

Stomach Problem Yes No

___ Heartburn

Heart Problem Yes No

___ High Blood Pressure

___ Heart Failure

Blood Disorder Yes No

___ Sickle Cell

___ High Cholesterol

Allergy/Immunology Yes No

___ Hayfever

___ HIV

___ Lupus

Kidney/Bladder Problem Yes No

Surgical Operations Yes No

Fever/Fatigue/Weight Loss Yes No

Cancer Yes No

Psychiatric Disorder Yes No

___ Anxiety

___ Depression

Musculoskeletal Conditions Yes No

___ Arthritis

___ Osteoporosis

Ear/Nose/Throat Problems Yes No

___ Sinus Problems

___ Dental Problems

Neurological Disorder Yes No

___ Migraine Headaches

___ Multiple Sclerosis

___ Myasthenia Gravis

___ Head Injury

___ Stroke

Are you currently being treated for any other medical condition? Yes No

If yes, what? _____

Date of last general health exam: _____ Date of last eye exam: _____ Previous eye care provider: _____

Please list any medications you are now taking

(including hormones, birth control, aspirin, or other anti-inflammatories, and eye drops):

Is there any possibility that you might be pregnant? Yes No N/A

Do you smoke or use tobacco? Yes No

Do you drink alcohol? Yes No

Are you allergic to any medications? Yes No If yes, please list: _____

Family History

Has anyone in your family had: Please check all that apply and indicate their relationship to you.

Yes No Diabetes _____

Yes No High Blood Pressure _____

Yes No Heart Disease _____

Yes No Respiratory Disease _____

Yes No Cancer _____

Yes No Cataract _____

Yes No Glaucoma _____

Yes No Macular Degeneration _____

Yes No Blindness _____

Yes No Other Eye Disease _____

Patient Lifestyle

Patient Name:

Today's Date:

1. Do you wear Glasses Contacts None

2. If you wear glasses, when do you wear your glasses? (CHECK ALL THAT APPLY)

- Driving Reading Driving at night Watching T.V.
 Using the computer Playing sports Doing fine point in workshop or hobbies

3. If you wear contacts, do you have a pair of glasses? Yes No

4. Do you have sunwear? Yes No

5. Do you wear a bi-focal? Yes No If so, is your bi-focal Lined No-line

6. Have any of the following been bothersome to you? (CHECK ALL THAT APPLY)

- Glare from on-coming lights at night
 Working long periods of time on the computer
 Overhead lighting at office or at home
 Tired eyes
 Glare from the sun
 Comfort or weight of current glasses
 Style and size of current glasses

7. Do you have sensitive skin or skin allergies? Yes No

8. Does your job or hobby require any of the following? (CHECK ALL THAT APPLY):

- Working in an industrial environment
 Working outdoors for extended periods of time
 Safety eye wear
 Driving more than 5-6 hours / day

9. On a scale of 1 to 4 (1 = Most Important and 4 = Least Important), rate how important EACH of the following is to you in selecting your eye wear.

_____ Comfort _____ Cosmetic Appearance

_____ Cost _____ Styles and Trends

10. Which best describes your fashion style?

- Conservative / Corporate Elegant / Sophisticated Doesn't matter to me
 Trendy / Stylish Funky / Fun

11. Are you interested in Laser Vision Correction?

- Yes No