# Mountain View Vision

Patient Registration Form

**Name:**

Patient Last Name:

_____

Patient First Name:

_____

**Gender:**

- ☐ Male
- ☐ Female
- ☐ Decline to specify

**Date of Birth:**

_____

**Patient SSN:**

_____

**Name of Parent/Guardian (If Applicable):**

_____

**Preferred Language:**

- ☐ English
- ☐ Spanish

Other: (please list below)

_____

**Email Address:**

_____

**Street Address:**

_____

**Employer/School Name:**

_____

**City:** **State:** **Zip:**

_____

**Occupation or Grade:**

_____

**Home Phone:** **Cell Phone:** **Work Phone:**

_____

**Preferred Contact Method:**

- ☐ Email
- ☐ Text Message
- ☐ Mail
- ☐ Phone

**Race/Ethnicity:**

- ☐ Native American
- ☐ Black/African American
- ☐ Hispanic/Latino
- ☐ Asian
- ☐ White
- ☐ Native Hawaiian/Pacific Islander
- ☐ Prefer Not to Answer

**Marital Status:**

- ☐ Married
- ☐ Single
- ☐ Divorced
- ☐ Widowed
- ☐ Prefer Not to Answer

**Were you referred to our office by another medical provider?**

- ☐ Yes (please provide name) _____
- ☐ No

**Chief concern for visit:**

**For patients 18 years old and under, please mark if you are experiencing any of the following:**

- ☐ Headaches
- ☐ Loss of place when reading
- ☐ Concerns about depth perception
- ☐ Difficulty focusing
- ☐ Difficulty with comprehension
- ☐ Variable vision

**Do you wear glasses?**

- ☐ Yes
- ☐ No

**Do you wear contacts?**

- ☐ Yes (what brand) _____
- ☐ No

**Name of Primary Care Provider:**

_____

**Phone number:**

_____

## Personal Medical & Eye History

**Please check if you *have or have had* any of the following:**

- ☐ Eye injury
- ☐ Surgery
- ☐ Retinal detachment/holes
- ☐ Flashes
- ☐ Floaters
- ☐ Eye turn/amblyopia
- ☐ Dry eye
- ☐ Macular degeneration
- ☐ Glaucoma
- ☐ Cataract
- ☐ Cancer
- ☐ Diabetes
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Heart disease
- ☐ Anxiety/depression
- ☐ Autoimmune disease
- ☐ Thyroid disease
- ☐ Learning/reading difficulties
- ☐ Alcohol use
- ☐ Tobacco use
- ☐ Other: _____

**Are you taking any medications? (Prescription and over the counter)**

- ☐ No
- ☐ Yes (please list)

**Do you have any medication allergies:**

- ☐ No
- ☐ Yes (please list)

## Family Medical & Eye History

**Please check if you have any family members with following:**

- ☐ Cataract
- ☐ Glaucoma
- ☐ Macular degeneration
- ☐ Eye turn/amblyopia
- ☐ Retinal detachment
- ☐ Diabetes
- ☐ Cancer
- ☐ Thyroid disease
- ☐ Heart disease
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Other: _____

**Please let our office know of any special needs/requests to better assist in your exam:**

**Insurance Information**. Please make a selection for both vision and medical insurance. Some of your care may be billed to your medical insurance. Your insurance cards will be scanned at your visit. If you have a secondary medical insurance, please also provide that information.

☐ I do not have vision insurance

| **Vision Insurance:** |
|---|
| **Subscriber's Name:** |
| **Subscriber's DOB:** |
| **Subscriber's SSN:** |
| **Insurance ID #:** |
| **Employer:** |

☐ I do not have medical insurance

| **Medical Insurance:** |
|---|
| **Subscriber's Name:** |
| **Subscriber's Date of Birth:** |
| **Subscriber's SSN:** |
| **Insurance ID #:** |
| **Employer:** |

**Payment Policy:** *By making an appointment at Mountain View Vision, you are agreeing to abide by all billing policies of our practice. Payment is required at the time services are rendered or materials are ordered. Quotes of insurance coverage are based on information from the insurance company and are not guaranteed. Although we will gladly bill insurance for you, the patient remains responsible for their charges even after the insurance has been billed. If payment has not been received from insurance after 60 days, the patient will be expected to pay Mountain View Vision directly.*

☐ I agree to the Payment Policy.

**Financial Responsibility:** *I understand that I am personally responsible for payment of my account even if I have insurance. If it becomes necessary to use a collection agency for any amount owed on this or subsequent visits, the undersigned agrees to pay all costs and expenses*

*including reasonable attorney's fees. Accounts assigned to collections will be charged a $50 collections fee.*

☐ I agree to the Financial Responsibility Policy.

**Cancellation Fee:** *A cancellation charge of $50 will be billed to you personally if you do not provide at least 24hours' notice of a cancellation or change in your appointment date or time.*

☐ I agree to the Cancellation Fee Policy.

**No Show Fee:** *A no show charge of $50 will be billed to you personally if you do not show for your scheduled appointment.*

☐ I agree to the No Show Fee Policy.

**Release of Information:** *I hereby authorize release of my information to my insurance company or to any healthcare professional or education professional when necessary for my health care billing. (This allows us to bill your insurance.)*

☐ I agree to the Release of Information Policy.

**Privacy Policy:** *We respect our legal obligation to keep health information private. We are obligated by law to give you notice of our privacy practices. If you would like to receive a copy of our Notice of Privacy Practices, please request one from the receptionist today or at any time in the future. I understand that Mountain View Vision has a Notice of Privacy Practices available for my review if I wish. At the present time, I acknowledge that this notice has been offered and I accept the Notice of Privacy Practices.*

☐ I agree to the Privacy Policy.

**These policies will be enforced for both new patients and established patients. Our staff will be happy to answer any further question regarding these policies.**

**Sign Name:** _____

**Date:** _____

**Relationship to patient (if signed by Parent/Guardian):** _____

## RELEASE FOR INTERNAL EYE HEALTH EXAM

This form is intended to help you make an informed decision regarding your exam.
A thorough internal examination of the eye is integral to an eye examination and required by the doctors of Mountain View Vision. Without a thorough internal examination, serious eye disease can be missed, including but not limited to diabetes, retinal detachment, hypertension, or malignant tumors.

Your Doctor's preferred method for this portion of the exam is an
Optomap retinal image. The Optomap takes a digital image of the retina that can be viewed within moments by the Doctor and saved in your records.

**The cost for the Optomap imaging is $42 (Adults, ages 18+) and $32 (Children under 18) and not typically covered by insurance.**

*Please select one of the following options:*

- ☐ **I understand the importance of the Optomap retinal exam and agree to pay the out-of-pocket cost at the time of service. **Doctor preferred method****
- ☐ **I alternatively choose to have my eyes dilated with eye drops to allow my doctor to conduct the internal eye health exam.**

**Sign Name:** _____

**Date:** _____

**Relationship to patient (if signed by Parent/Guardian):** _____

**Are you interested in or currently wear contacts?**

**-If No, please skip this section.**

**-If Yes, please read and sign below**

## Contact Lens Fitting Agreement

To provide our patients with the highest standard of care, all patients are *REQUIRED* to have a comprehensive vision health examination by our doctors prior to the contact lens fitting or contact lens evaluation. The contact lens fitting is for new contact lens wearers or existing contact lens wearers who need substantial changes in lens design for health or vision reasons. The contact lens evaluation is for established contact lens wearers to ensure that the health of the eye has not been compromised and changes are necessary in the lens design or fit.

**Contact Lens Fitting and Evaluation Fees:**

**Contact Lens Evaluation: $70**

**Mini Fit: $90 (for established patients with a small design or material change)**

**Spherical Fit: $125**

**Toric Fit: $155**

**Custom Toric Fit: $185**

**Multi-Focal Fit: $185**

I understand that the contact lens prescription will be valid for *one year* and that an annual eye and contact lens examination will be required to update this prescription. I understand that wearing my contact lenses for more than the prescribed time or improper care increases my risk of infection, discomfort, and poor lens performance.

**Sign Name:** _____

**Date:** _____

**Relationship to patient (if signed by Parent/Guardian):** _____

# Dry Eye Symptoms and Severity

Dry Eye Disease is the most frequent reason that patients visit eye doctors. We are concerned that you may be suffering with this condition as well. Therefore, we ask that you take a few moments and thoughtfully complete the questionnaire below.

Report the FREQUENCY that you experience the following symptoms:

**Dryness, Grittiness or Scratchiness**
- ☐ Never
- ☐ Sometimes
- ☐ Often
- ☐ Constant

**Soreness or Irritation**
- ☐ Never
- ☐ Sometimes
- ☐ Often
- ☐ Constant

**Burning or Watering**
- ☐ Never
- ☐ Sometimes
- ☐ Often
- ☐ Constant

**Eye Fatigue**
- ☐ Never
- ☐ Sometimes
- ☐ Often
- ☐ Constant

**Do you have fluctuating vision problems? (That can be corrected with blinking)**
- ☐ Never
- ☐ Sometimes
- ☐ Frequently
- ☐ A Lot/Always

**Do you use eye drops and/or ointment?**
- ☐ Yes (please list)

  _____
- ☐ No

Report the SEVERITY of your symptoms:

**Dryness, Grittiness or Scratchiness**
- ☐ No problems
- ☐ Tolerable – not perfect but not uncomfortable
- ☐ Uncomfortable – irritating but does not interfere with my day
- ☐ Bothersome – irritating and interferes with my day
- ☐ Intolerable – unable to perform my daily tasks

**Soreness or Irritation**
- ☐ No problems
- ☐ Tolerable – not perfect but not uncomfortable
- ☐ Uncomfortable – irritating but does not interfere with my day
- ☐ Bothersome – irritating and interferes with my day
- ☐ Intolerable – unable to perform my daily tasks

**Burning or Watering**
- ☐ No problems
- ☐ Tolerable – not perfect but not uncomfortable
- ☐ Uncomfortable – irritating but does not interfere with my day
- ☐ Bothersome – irritating and interferes with my day
- ☐ Intolerable – unable to perform my daily tasks

**Eye Fatigue**
- ☐ No problems
- ☐ Tolerable – not perfect but not uncomfortable
- ☐ Uncomfortable – irritating but does not interfere with my day
- ☐ Bothersome – irritating and interferes with my day
- ☐ Intolerable – unable to perform my daily task