Heartland Eye Consultants
Low Vision Demographics

Patient:

Last Name: ___________________________ First Name: _____________________ M.I. _____

Street Address: ________________________ Apt #______ Gender: ○Male ○Female

City: ______________________ State: _____ Zip Code: _________

Date of Birth: ___/___/_______ Soc. Sec. No. ____-____-_______

Cell: (___) _____________ ○Home: (____) ___________ ○Work: (____)___________

Do you have an email address we could use to confirm appointments?

____ ○Yes ○No

Marital Status: ○Single ○Married ○Divorced ○Separated ○Widowed

Primary Language: ○English ○Spanish ○French ○Other____________ ○I decline

Race: ○American Indian or Alaska Native ○Asian ○African-American
○Pacific Islander ○White ○Other Race ○I decline

Ethnicity: ○Not Hispanic or Latino ○Hispanic or Latino ○I decline

Special Needs: ○Hearing Impaired ○Wheelchair ○Translator ○None

Occupation: ___________________________ Employer: ___________________________

Employer's Address: ___________________________

City, State, Zip: _________________________________

Is this visit a result of an accident or illness *that occurred at work*? Yes No

If not, please list ___________________

Which doctor referred you to our office? _________________________

Who performed your last eye exam? _____________________________ Date: ____/____/__

Pediatrician/Family Physician: ________________________

Emergency Contact: ______________________ Relationship: ____________ Phone _______
(Not living in household)

If the patient is married, please complete spouse information:

Spouse's Last Name: ________________ First Name: ____________ M.I.____

Birthdate: ____/____/_____

Cell Phone: ______________ Home Phone: _________________

Email Address: ___________________________

SSN:_________________ Employer: _______________ Occupation ________________

Title: ____________

Employer's Address _____________________________ City__________________

State ______ Zip_______

The person requesting services is the responsible party.

We will file major medical insurance coverage for you if you provide us with a copy of your current card. For patients without insurance coverage, you will be responsible for payment. Please indicate your preferred method of payment: Cash Check Credit Card (Mastercard/Visa)

Photo Release:
I hereby grant Heartland Eye Consultants, L.L.C. and Developmental Vision Associates, P.C. permission to have my photograph taken for patient information. This does not allow them to use my likeness in photographs and/or video in any of its publications or media.

AUTHORIZATION TO RELEASE INFORMATION TO YOUR INSURANCE COMPANY AND ACKNOWLEDGEMENT OF PERSONAL RESPONSIBILITY FOR PAYMENT

I hereby assign all medical benefits (to which I am entitled) to the doctor caring for me. This includes major medical benefits, Medicare, Medicaid, private insurance and any health plans in which I am enrolled. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not they are paid by my insurance and that 15% APR will be applied to all accounts not paid within 30 days. I hereby authorize the holder of my medical and patient registration records to release any information need to process my insurance claims. I understand that I am the guarantor of this account.

$15 Fee may incur if a copy of my medical records are requested in writing and will be provided whomever I designate.
$25 Fee will incur for all returned checks.
$50 A deposit will be required to schedule an appointment if you fail to keep previous appointments or if you repeatedly reschedule your appointment with less than 48 hours notice. This fee will be credited to your bill if you attend.
****I authorize communication of my medical records to be released to: ____**

Authorized Signature: ______________________________________Date of Signature: ______________

PLEASE INITIAL ________ You have read and are aware of the HIPAA privacy policy and agree with it's provisions.

Low Vision History

Patient Name:___________________________ Date of Birth:________________

Please answer the following questions. This will help the doctor to better understand your problems. Thank you.

1) Do you understand your diagnosis to your satisfaction? ☐ Yes ☐ No

Comments:
____
____

2) Do you have problems with any of the following? (Please mark all that apply.)

☐ Hearing, which side? ________ ☐ Walking without falling ☐ Tremors, which side? ______

5) Which of the following conditions do you have? (Please mark all that apply.)

Alzheimer's disease _____	Dementia _____	High blood pressure ______
Arthritis _____	Depression _____	Lupus _____
Asthma _____	Diabetes _____	Osteoporosis _____
Cancer _____	Emphysema _____	Sinus condition _____
COPD _____	High Cholesterol _____	Stroke _____
		Traumatic Brain Injury _____

6) Which of the following describes your living situation?

☐ Independent living ☐ Nursing home ☐ With a son/daughter ☐ Alone ☐ Parent

7) Have you ever had training with any low-vision devices?

☐ Extensive ☐ Moderate ☐ Very little ☐ None

8) Which of the following low-vision devices do you utilize?

☐ None	☐ Closed-circuit television (CCTV)
☐ Hand-held magnifier	☐ Electronic magnification device
☐ Binoculars	☐ Smart Phone
☐ Kindle / Nook	☐ Computer
☐ Other ____	

9) Which of the following activities would you enjoy more if your vision permitted?

☐ Social gatherings ☐ Sporting events ☐ Television
☐ Card games ☐ Cooking ☐ Other ______________

11) Do you have any family members that help you with daily activities?

☐ Spouse ☐ Sister ☐ Brother ☐ Children ☐ Grandchildren ☐ Parent

13) Which methods of transportation do you use? (Please check all that apply)

☐ I drive ☐ I get rides from family members and friends ☐ I use public transportation

14) Which of the following would you like to improve?

Near Activities:

☐ Reading newsprint ☐ Reading large print ☐ Reading books
☐ Reading headlines ☐ Reading the mail ☐ Dialing the phone
☐ Seeing colors of clothing ☐ Cooking ☐ Seeing food on plate
☐ Seeing the stove dials ☐ Personal grooming (shaving, lipstick, etc)

Distance Activities:

☐ Watching television ☐ Recognizing faces ☐ Driving

_______________________ Signature

_______________________ Date of Completion

Please return to the receptionist when you are finished. Thank you!