**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) (Area Code)

## 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_____

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## 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 its 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 Front Desk staff when you are finished. Thank you!