



Please complete the following information. If you have any questions, please ask the receptionist for assistance.

Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_  
 Male \_\_\_\_ Female \_\_\_\_  
 Married \_\_\_\_ Single \_\_\_\_

Name \_\_\_\_\_ Preferred Name \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Child's S.S.# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 Father's Name \_\_\_\_\_ Mother's Name \_\_\_\_\_  
 Father's S.S.# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Mother's S.S.# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 Father's Work Number \_\_\_\_\_ Mother's Work Number \_\_\_\_\_  
 Insurance \_\_\_\_\_ Child's Pediatrician \_\_\_\_\_

How did you hear about this office? \_\_\_\_\_  
 When was the child's last eye exam? \_\_\_\_\_ Doctor \_\_\_\_\_

**Insurance Information**

**Primary Medical Insurance** \_\_\_\_\_ Member/Employee Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Member/Employee Name \_\_\_\_\_ Member/Employee Work Phone \_\_\_\_\_  
 Member/Employee ID# \_\_\_\_\_ Member/Employee Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 Employer/Work Name \_\_\_\_\_ Group/Policy Number \_\_\_\_\_

**Vision or Secondary Medical Insurance** \_\_\_\_\_ Member/Employee Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Member/Employee Name \_\_\_\_\_ Member/Employee Work Phone \_\_\_\_\_  
 Member/Employee ID# \_\_\_\_\_ Member/Employee Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 Employer/Work Name \_\_\_\_\_ Group/Policy Number \_\_\_\_\_

I request that payment of authorized insurance benefits be made on my behalf to Dr. Carl Vinson for any services furnished me by this provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

We consider it an honor to serve you. For your convenience we honor all major credit cards, personal checks, and cash. Revolving credit is available upon credit approval. Payment is expected when services are rendered. I understand that in the event my account is not paid according to terms, I will be responsible for, in addition to the balance due, all costs of collection, including collection agency fees, court costs and reasonable attorney's fees.

Signed \_\_\_\_\_ Date \_\_\_\_\_

# Medical History Questionnaire

Name: \_\_\_\_\_

Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

## Medical History

Does your child have any allergies to medications?  no  yes If yes, explain: \_\_\_\_\_

List any medications your child takes (including oral contraceptives, aspirin, over the counter medications and home remedies):

List all major injuries, surgeries and/or hospitalizations your child has had: \_\_\_\_\_

Has your child ever had any of the following? (circle)

crossed eyes      lazy eye      drooping eyelid      prominent eyes.      glaucoma  
retinal disease      cataracts      eye infections      eye injury

Explain: \_\_\_\_\_

Is your child pregnant and/or nursing?  no  yes  
Does he/she wear glasses?  no  yes If yes, how old is the present pair of lenses? \_\_\_\_\_  
Does he/she wear contact lenses?  no  yes If yes, how old is the present pair of lenses? \_\_\_\_\_  
Type of contact lenses:  Rigid  Soft  Extended Wear  Other Are they comfortable?  yes  no

## Family History

Please note any family history (parents, grandparents, siblings, children, living or deceased) for the following conditions:

DISEASE	NO	YES	?	RELATIONSHIP TO YOUR CHILD
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

☺ Please turn this form over and complete side two ☺



**Social History** *This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.*

*Yes, I would prefer to discuss my child's Social History directly with the doctor. (Check box)*

Does your child drive?  no  yes

If yes, does he/she have visual difficulty when driving?  no  yes If yes, please describe: \_\_\_\_\_

Does your child use tobacco products?  no  yes If yes, type/amount/how long: \_\_\_\_\_

Does your child drink alcohol?  no  yes If yes, type/amount/how long: \_\_\_\_\_

Does your child use illegal drugs?  no  yes If yes, type/amount/how long: \_\_\_\_\_

Has your child ever been exposed to or infected with:  Gonorrhea  Hepatitis  HIV  Syphilis

**Review of Systems**

Does your child currently, or has he/she ever had any **persistent** problems in the following areas:

SYSTEM	NO	YES	?		NO	YES	?
<b>CONSTITUTIONAL</b>				<b>EARS, NOSE, MOUTH, THROAT</b>			
Fever, Weight Loss/Gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergies/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>INTEGUMENTARY (Skin)</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>NEUROLOGICAL</b>				Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Post-Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dry Throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>EYES</b>				<b>RESPIRATORY</b>			
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Distorted Vision/Halos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>VASCULAR / CARDIOVASCULAR</b>			
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sandy or Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>GASTROINTESTINAL</b>			
Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>GENITOURINARY</b>			
Excess Tearing/Watering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genitals/Kidney/Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glare/Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>BONES / JOINTS / MUSCLES</b>			
Eye Pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Infection of Eye or Lid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flashes/Floaters in Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>LYMPHATIC / HEMATOLOGIC</b>			
<b>ENDOCRINE</b>				Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid/Other Glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				<b>ALLERGIC / IMMUNOLOGIC</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				<b>PSYCHIATRIC</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you answered YES to any of the above questions or your child has a condition NOT listed, please explain:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Doctor's Signature

Date



**Consent to Examine, Diagnose, and Initiate Treatment**

I, \_\_\_\_\_, do hereby consent to treatment for myself. I give permission for the doctor(s) to examine, diagnose, and initiate treatment as deemed appropriate.

\_\_\_\_\_  
(Patient Signature)

\_\_\_\_\_  
(Date)

Master





## PATIENT CONSENT/ACKNOWLEDGEMENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. This includes, but is not limited to, disclosure to third party medical care providers to whom we refer you or with whom we consult regarding your health, as well as to third parties for payment or billing purposes. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- Dr. Carl Vinson has a Notice of Privacy Practices and that the patient has the opportunity to review this notice.
- Dr. Carl Vinson reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information but Dr. Carl Vinson does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- Dr. Carl Vinson may condition treatment upon the execution of this Consent.

I request that a copy of the "Notice Of Privacy Practices"  be given /  not be given to me

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Printed Name - Patient or Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to patient (if other than patient)

In front of \_\_\_\_\_

Optional Screening with Ultra Wide Field Photos of the inside of your eyes. ----

An exam of the retina (the inner lining of your eyes) can lead to early detection of common eye diseases, as well as signs of other diseases including hypertension, diabetes, and even brain tumors. Unfortunately, patients may experience some discomfort during the exam which involves dilated pupils and a bright exam light.

Optional screening photos offer several advantages:

- (1) Does not require dilation with eye drops.
- (2) No need for temporary sunglasses since eyes are not dilated.
- (3) Painlessly captures retinal images in just a few seconds.
- (4) In most cases, eliminates the need for dilation eye drops.
- (5) Produces high resolution photos which your doctor can review with you.
- (6) The images become part of your medical record for future comparisons.

Screening photos such as these are not covered by vision or medical insurance.

I choose screening digital retina photos - cost \$39.00

I choose traditional dilated retinal exam with dilation eye drops (usually covered by vision or medical insurance, except for usual deductibles and co-pays)



# Lifestyle Index

PT INITIALS / ID \_\_\_\_\_

DATE \_\_\_\_\_

This questionnaire is meant to help your doctor understand what you're experiencing on a regular basis — **whether it's caused by your eyes, posture, stress, etc.** Your responses will help make sure you receive the best care possible.

How often do you experience any of these symptoms? Fill in applicable circle. For example: 1 2 3 4 5



**Headaches**

- You get headaches of any severity each week (even just a dull ache counts).
- Your headaches tend to get worse later in the day.

1 Never	2 Rarely	3 Sometimes	4 Very Often	5 Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Additional notes: \_\_\_\_\_



**Stiffness / pain in neck / shoulders**

You experience stiffness/tension in your neck/shoulders when you work at a computer or read (this might even be from your posture).

1 Never	2 Rarely	3 Sometimes	4 Very Often	5 Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Additional notes: \_\_\_\_\_



**Discomfort with Computer Use**

Your eyes get tired, burn, or get red easily when you work at a computer for long hours.

1 Never	2 Rarely	3 Sometimes	4 Very Often	5 Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Number of hours per day using a digital device: \_\_\_\_\_



**Tired Eyes**

Your eyes feel increasingly fatigued/tired as the day goes on.

1 Never	2 Rarely	3 Sometimes	4 Very Often	5 Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Additional notes: \_\_\_\_\_



**Dry Eye Sensation**

Your eyes progressively feel more dry/sandy/gritty while working at the computer or reading.

1 Never	2 Rarely	3 Sometimes	4 Very Often	5 Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Additional notes: \_\_\_\_\_



**Light Sensitivity**

Bright / Strong lights (vehicle headlights, florescent lights etc.) bother you.

1 Never	2 Rarely	3 Sometimes	4 Very Often	5 Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Additional notes: \_\_\_\_\_



**Dizziness**

You experience dizziness, motion sickness, or vertigo.

1 Never	2 Rarely	3 Sometimes	4 Very Often	5 Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Additional notes: \_\_\_\_\_



**Additional Notes**

Any additional notes you'd like to add: \_\_\_\_\_

Email: \_\_\_\_\_