

## Welcome to Jarvis Vision Center!

Please fill out the following information to the best of your ability.  
Ask for assistance if needed.



### Personal Information

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Street Address: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_ Sex:            M            F  
Spouse/Parent's Name: \_\_\_\_\_ Spouse Date of Birth: \_\_\_\_\_  
Employer: \_\_\_\_\_ Spouse Employer: \_\_\_\_\_  
Primary Language:            English            Spanish            Other, please specify:  
Marital Status:            Single            Married            Divorced            Widowed

### Communication

Home phone #: \_\_\_\_\_ Work phone #: \_\_\_\_\_  
Cell phone #: \_\_\_\_\_ Email Address: \_\_\_\_\_  
Preferred method of communication    Text            Phone            Email            Mail  
May we contact you via email or text?    Y            N

### Referrals

How did you hear about our office?  
Who can we thank for referring you today?

### Insurance Information

#### **Vision Ins. Company Name:**

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Name of Insured: \_\_\_\_\_ SS#: \_\_\_\_\_ DOB: \_\_\_\_\_

#### **Medical Ins. Company Name:**

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Name of Insured: \_\_\_\_\_ SS#: \_\_\_\_\_ DOB: \_\_\_\_\_

### Personal Ocular History

Primary Eye Care Doctor: \_\_\_\_\_ Last Visit: \_\_\_\_\_  
Do you currently wear glasses?    Y            N            Date of current pair: \_\_\_\_\_  
Do you wear contact lenses?    Y            N            Brand of contacts: \_\_\_\_\_  
How often do you replace them?    Daily            Monthly            Other: \_\_\_\_\_

#### **Have you ever been diagnosed with the following conditions? Check all that apply:**

Glaucoma	Cataracts	Macular Degeneration
Dry Eyes	History of Eye Infections	History of Eye Injuries
History of Eye Surgeries	Lazy eye/Cross eyes	Diabetic Eye Disease

## Personal Health History

Primary Care Doctor:

Last Visit:

Approximate Height:           ft                   in

Weight:                                   lbs

### Medications

Please list or attach all prescription and non-prescription medications/supplements taken regularly:

What is your preferred pharmacy?

### Allergies

Please list all known allergies.

### Social History

Do you use tobacco products?           Y    N                                   Do you drink alcohol?           Y    N

Are you currently pregnant?           Y    N                                   Due Date:

### Diabetic History

Age when diagnosed:                                   Doctor treating your diabetes:

Last Blood Sugar Reading:                                   Date:

Last Hemoglobin A1C:                                   %    Date:

### **Have you ever been diagnosed with the following conditions? Check all that apply:**

Diabetes	Thyroid	Bleeding Disorder	High Blood Pressure
High Cholesterol	Heart Disease	Stroke	Migraines
Sinusitis	Asthma	COPD	Colitis/Crohns
Arthritis	Lupus	Menopause	Depression
Sleep Apnea	Skin Cancer	Other Cancer	Other Conditions

### Family Health History    **Has anyone in your immediate family been diagnosed with the following conditions? Check all that apply:**

	Mother	Father	Brother	Sister	Son	Daughter
<b>Glaucoma</b>						
<b>Cataracts</b>						
<b>Macular Degeneration</b>						
<b>Retinal Disease</b>						
<b>Amblyopia/ Strabismus</b>						
<b>Blindness/Loss of Vision</b>						
<b>Diabetes</b>						
<b>Cancer</b>						
<b>Hypertension</b>						
<b>Thyroid Dysfunction</b>						



## **Patient Acknowledgement of Financial Responsibility**

### **Medical Insurance & Vision Plans:**

Jarvis Vision Center is committed to caring for our patient's complete ocular health. We provide both routine vision exams, as well as diagnosis and treatment of eye conditions. Routine vision exams **where there is no medical complaint or diagnosis**, will be filed to your vision plan if applicable. If you have a medical complaint or diagnosis, your exam will no longer be considered routine. In these instances, we are **required** to bill your examination to your medical insurance. Please give all insurance information to check-in upon arrival. It is your responsibility to have all insurance cards at the time of your appointment.

### **Contact Lens Evaluation & Fitting:**

Contact lenses are medical devices regulated by the FDA. Your optometrist is required to evaluate the health of your eyes and the fit of your contacts every year in order to determine the best prescription for your eyes. For this service, all contact lens patients will be charged a contact lens fitting and evaluation fee. Most vision and insurance plans require that this be billed separately and do not cover this fee, as contact lenses are considered to be "cosmetic." Patients being fitted with contacts for the first time, who require insertion and removal training or who are being fit with a new contact lens material will be charged \$85. Patients previously fit with contacts who require only a new prescription in a previously worn material will be charged \$55.

### **Patient Responsibilities & Agreement:**

I understand it is my responsibility to know:

- The name of my insurance company
- The amounts of my copays
- My benefits (what is covered and not covered)
- If a prior authorization is required

I understand that any amounts not covered by my insurance for services received are my financial responsibility.

I understand that all copays are due at the time of my appointment. On glasses, 50% is required on the order date and the remaining balance is due on the pick-up date. On contact lens orders, payment is required in full at time of pick-up.

PATIENT'S NAME:

SIGNATURE:

DATE:

GUARDIAN SIGNATURE (if patient is under 18)



**ACKNOWLEDGEMENT OF  
NOTICE OF PRIVACY PRACTICES**

The law requires that Jarvis Vision Center, PLLC make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

I have read or had explained to me Jarvis Vision Center, PLLC's Notice of Privacy Practice and agree to continue my care with Jarvis Vision Center, PLLC under said terms.

I authorize Jarvis Vision Center, PLLC to release my personal health information to the following individuals:

Name Relationship to Patient

Name Relationship to Patient

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

Patient Name (Printed)

Patient/Parent/Guardian Signature

Date

If you are signing as a personal representative of the patient, please indicate your relationship.



## REQUEST FOR LIST OF PRESCRIPTIONS

*Private and Confidential*

In order to check for drug allergies or interactions, we are required to obtain an official list of your medications from your primary care provider and perform a Medication Reconciliation.

Please provide the following information about your provider and sign the release below. We will contact your provider and request a confidential electronic record be sent to our office via fax or secure direct email.

Primary Care Provider:

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Office:

Doctor:

Fax #:

I authorize the primary care physician listed above to release medication information to Jarvis Vision Center. Please send a copy of my **Summary of Care Record**, showing my **Active Medication List** to Jarvis Vision Center.

- Fax: (270) 759-1493
- Secure Email:
  - Dr. Jarvis [rjarvis@direct.revolutionehr.com](mailto:rjarvis@direct.revolutionehr.com)
  - Dr. Williams [jesse.williams@direct.revolutionehr.com](mailto:jesse.williams@direct.revolutionehr.com)

I do not have a primary care provider.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

Patient Full Name

Date of Birth

Patient Signature

Date Signed

Guardian or Personal Representative

Relationship to Patient

Guardian or Personal Representative

Date Signed

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**To be completed by Primary Care Provider. Please Indicate One:**

- Summary of Care record with active medication list is attached
- No active prescriptions on file