LeClear Vision Center - (502)420-0173

Guardian: ______ **Date:** ______

Name: ______

Address: ______

City, St: ______ **Zip:** ______

Phone(H): ______ **(W):** ______

Date of Birth: ______ **Sex:** ______

Vision or Primary Insurance

Ins.: ______ **#:** ______

Insured: ______ **DOB:** ______

Relationship:

Medical or Secondary Insurance

Ins.: ______ **#:** ______

Insured: ______ **DOB:** ______

Relationship:

E-Mail: ______

Contact me by: ☐ Phone ☐ Email ☐ Mail ☐ Text

Occupation: ______

Medical Doctor(s):

Approx. Date of Last Eye Exam:

Allergies

- ☐ None
- ☐ Penicillin
- ☐ Sulfa
- ☐ Eye drops
- ☐ Novocain
- ☐ Seasonal
- ☐ Codeine
- ☐ Other...

Current Medicines

Past Medical History

☐ Ambylopia ☐ Arthritis ☐ Autoimmune ☐ Asthma ☐ Cancer ☐ Cataract ☐ Crossed eyes ☐ Diabetes ☐ Droopy lid ☐ Eye infections
☐ Eye injuries ☐ Eye Surgery ☐ Glaucoma ☐ Heart Disease ☐ Keratoconus ☐ Kidney ☐ LASIK ☐ Lazy eye ☐ Lupus ☐ Migraine
☐ MS ☐ Neurological ☐ Sinus ☐ Psychological ☐ Respiratory ☐ Thyroid ☐ Gastrointestinal ☐ Ear/Nose ☐ Macular Degen. ☐ High B.P.
☐ Other...

Eye wear History (have you ever worn...)

☐ Glasses ☐ Bifocals ☐ Trifocals
☐ No- line ☐ Soft Contacts ☐ Toric Soft
☐ Gas Perm ☐ Hard ☐ Monovision
☐ Disposable ☐ Overnight wear ☐ Other...

Family History (parents, grandparents, siblings)

☐ Blindness ☐ Cataracts ☐ Crossed Eyes ☐ Color Blind ☐ Diabetes
☐ Kidney Disease ☐ Macular Degen. ☐ Retina Disease ☐ Retina Detach ☐ Heart Disease
☐ High B.P. ☐ Thyroid ☐ Glaucoma ☐ Cancer ☐ None
☐ Other...

Social History

☐ Computer ☐ Reading ☐ Tobacco Use ☐ Drug Abuse ☐ Alcohol Abuse
☐ Student ☐ Music ☐ Skiing ☐ Golf ☐ Fishing
☐ Tennis ☐ Shoot ☐ Scuba ☐ Swim ☐ Bike
☐ Non-smoker ☐ No alcohol or drug abuse ☐ Other...

Current eye problem(s) (please circle the "main" problem)

☐ Blur at Far ☐ Blur at Near ☐ Blur at Far & Near ☐ Red eye ☐ Itching ☐ Burning ☐ Redness ☐ Eye pain ☐ Eye strain
☐ Flashes/Floaters ☐ Loss of vision ☐ Loss of side vision ☐ Double vision ☐ Sandy/Gritty Feeling ☐ Foreign Body Sensation ☐ Spots or shadows ☐ Diabetes eye check ☐ Medical eye check
☐ Other...

☐ Right eye ☐ Left eye ☐ Both eyes

☐ Mild ☐ Moderate ☐ Severe

☐ Started today ☐ 1-2 days ☐ 3-7 days ☐ 1-2 weeks ☐ 2-4 weeks ☐ 1-3 months ☐ 3-6 months ☐ Over 6 months

☐ Getting better ☐ Getting worse ☐ Worse AM ☐ Worse PM

Are you interested in contact lenses information?

☐ Try Contacts ☐ Upgrade Contacts ☐ No interest in Contacts

Our office requires payment at the time of service unless we "accept assignment" on your insurance. You are responsible if your insurance doesn't pay. We charge $2.00 every 2 weeks on balances over 60 days. If we have to place your account in collections, you will be responsible for all collection fees, attorney's fees, court costs and interest accrued. **Contact lens fit and followup care are billed separately from your eye exam.** Your information is protected by our privacy policy - ***I have received and read the LeClear Vision Center "Notice of Privacy Practices". I understand my rights contained in this notice. By way of my signature, I provide this practice with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.***

Signature______________________ Date______________

5020 Norton Healthcare Boulevard
Louisville, KY 40241

Missed appointments, not being on time for your appointment or appointments not cancelled within 24 hours are a lost opportunity for us to help another patient with their sight. We ask that you give us at least **24 hours notice** of cancellation / reschedule.

A charge of $25.00 will be billed to the patient if the appointment is not cancelled / rescheduled 24 hours prior to the appointment time. This charge will be the patient's responsibility. Two or more missed, late or rescheduled appointments **without 24 hours notice** may lead to you being prohibited from making appointments for a year's time.

Thank you,
LeClear Vision Center

I have read and understood this cancellation / reschedule policy:

____
Patient or Patient's Representative's Signature

ACKNOWLEDGMENT of Privacy Policy:

Your information is protected by our privacy policy - I have read the LeClear Vision Center's "Notice of Privacy Practices". I understand my rights contained in this notice. By way of my signature, I provide this practice with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

________________________________ Patient or Patient's Representative's Signature

________________________________ Representative's Relationship to Patient

____
Date