Visions Eye Care
Welcome To Our Office

Welcome to Visions Eye Care + Therapy Center! Thank you for choosing us for your eye care needs. We are delighted to have you as a patient and appreciate the confidence you placed in us. Please take a moment to complete the following information. If you have any questions, please do not hesitate to ask.

☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms. ☐ Male ☐ Female

First Name | MI | Last Name | Preferred Name

Street Address | City | State | Zip

Social Security Number | Date of Birth | Home Phone - Include Area Code | Day Phone

Email Address | Guardian | Person Responsible for Account

Race

☐ American Indian Or Alaska Native
☐ Asian
☐ Black Or African American
☐ Hispanic Or Latino
☐ Native Hawaiian Or Other Pacific Islander
☐ White
☐ Declined To Specify

Other Race

Ethnicity

○ Hispanic Or Latino ○ Not Hispanic Or Latino ○ Declined

Preferred Language

○ English	○ German	○ Japanese	○ Portuguese
○ Chinese	○ Hindi	○ Korean	○ Russian
○ Dutch; Flemish	○ Indonesian	○ Mongolian	○ Spanish; Castilian
○ French	○ Italian	○ Polish	○ Vietnamese

Height ft in cm/m ◉ ft in ○ cm ○ m **Weight** ◉ lbs ○ kg

DILATION CONSENT

As your eye care professionals, Dr. Gulbranson, Dr. Hupke, Dr. Gentrup and Dr. Ackerman recommend that all of our patients receive a dilated eye examination as part of their comprehensive visual analysis. The dilation helps the doctor obtain a better view of the peripheral retina and can assist in early detection of glaucoma, cataracts, macular degeneration, diabetic retinopathy, retinal holes, tears and detachments.

Please initial below:

_____ I do consent to having my eyes dilated if the doctor feels it is necessary.

_____ I do not want my eyes dilated at this time. I do understand the importance of the dilation, yet I do not wish to have this performed at this time. I release Dr. Gulbranson, Dr. Hupke, Dr Gentrup and Dr. Ackerman from any liability related to the failure to treat or diagnose any eye conditions due to the lack of diagnostic information, which could have been obtained by this test.

Visions Eye Care
PATIENT HISTORY AND INFORMATION

DATE OF LAST EYE EXAM _____

EYE DISEASES (check those you have had)

- ____ Amblyopia
- ____ Blepharitis
- ____ Blindness
- ____ Cataract(s)
- ____ Color Blindness
- ____ Diabetic Retinopathy
- ____ Dry Eye Syndrome
- ____ Eye Injuries
- ____ Glaucoma
- ____ Glaucoma Suspect
- ____ High Risk Medication
- ____ Macular Degeneration
- ____ PVD (Posterior Vitreous Detachment)
- ____ Retinal Detachment
- ____ Strabismus

CURRENT EYE SYMPTOMS (check those you are experiencing)

- ____ Glare Sensitivity
- ____ Headaches
- ____ Light Sensitivity
- ____ Tired Eyes
- ____ Burning
- ____ Dryness
- ____ Excessive Tearing
- ____ Eyelid Swelling
- ____ Eye Pain or Soreness
- ____ Foreign Body Sensation
- ____ Infection of Eye or Lid
- ____ Itching
- ____ Mucous
- ____ Ptosis (Drooping Eyelid)
- ____ Redness
- ____ Sandy or Gritty Feeling
- ____ Blurred Vision Distance
- ____ Blurred Vision Near
- ____ Distorted Vision (halos)
- ____ Double Vision
- ____ Flashes of Lights
- ____ Floaters or Spots
- ____ Fluctuating Vision
- ____ Loss of Central Vision
- ____ Loss of Side Vision
- ____ Loss of Vision
- ____ Other

GENERAL HEALTH CONDITION (check those you have had)

- ____ Fever
- ____ Unexplained Weight Loss
- ____ Other Symptoms
- ____ Ears,Nose,Throat
- ____ Cardiovascular (high blood pressure etc.)
- ____ Respiratory (Asthma)
- ____ Gastrointestinal
- ____ Kidney
- ____ Muscles,Bones,Joints
- ____ Skin
- ____ Neurological (Multiple Sclerosis)
- ____ Anxiety or Depression
- ____ Thyroid, Diabetes
- ____ Blood/Lymph
- ____ Allergic

FEMALE HISTORY:

Are you currently pregnant? ○ Yes ○ No

Are you currently nursing? ○ Yes ○ No

Primary Care Physician: _____

Major Illnesses: _____ _____

Past Surgeries: _____ _____

Current Medications: _____ _____

_____ _____

Current Eye Drops: _____ _____

Specific Allergies & Reactions: _____

FAMILY HISTORY (Check those someone in your family has had & indicate relationship to you. Please specify maternal/paternal.)

- ____ Amblyopia (Lazy Eye) _____
- ____ Blindness _____
- ____ Cataract(s) _____
- ____ Color Blindness _____
- ____ Glaucoma _____
- ____ Macular Degeneration _____
- ____ Retinal Detachment _____
- ____ Strabismus (Eye Turn) _____
- ____ Arthritis _____
- ____ Cancer _____
- ____ Diabetes _____
- ____ Heart Disease _____
- ____ High Blood Pressure _____
- ____ Kidney Disease _____
- ____ Lupus _____
- ____ Stroke _____
- ____ Thyroid Disease _____
- ____ Others _____

Visions Eye Care
PATIENT HISTORY AND INFORMATION

SOCIAL HISTORY

Employer/School: _____ Occupation/Grade: _____

Do you drink alcohol? ○ No ○ Occasional ○ 1 per day ○ 2-3/day ○ 4+/day

Do you smoke?

○ Never Smoker ○ Current some day smoker

○ Former Smoker ○ Current every day smoker

SPECTACLE LENS HISTORY

Do you currently wear glasses ? ○ Yes ○ No

Type Of Glasses: ☐ FullTime ☐ PartTime ☐ Distance ☐ Close

CONTACT LENS HISTORY

Do you currently wear contact lenses? ○ Yes ○ No

If not a contact lens wearer, are you interested in trying contact lenses at this time ? ○ Yes ○ No

HOW WERE YOU REFERRED TO OUR OFFICE?

☐ Phone Book ☐ School ☐ Advertisement ☐ Patient (Please Name) _____

☐ Insurance Listing ☐ Drive by ☐ Other _____ ☐ Doctor (Please Name) _____

IF PATIENT IS A MINOR:

I _____ certify that I am the:

☐ parent ☐ legal guardian of _____ and by signing below, I am giving permission for this patient to be treated by Visions Eye Care & Vision Therapy Center.

BILLING

In order to control the cost of billing, we ask that the patient's portion is paid at the time services are rendered. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks.

I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed.

ABOUT YOUR INSURANCE

There are two types of health insurance that will help pay for your eye care services and products. You may have both and our practice accepts both:

1. Vision care plans (such as VSP and EyeMed)
   - Vision care plans only cover routine vision exams along with eyeglasses and contact lenses. Vision plans only cover a basic screening for eye disease. They do not cover diagnosis, management or treatment of eye diseases.
2. Medical insurance (such as Blue Cross Blue Shield and Medicare).
   - Medical insurance must be used if you have any eye health problem or systemic health problem that has ocular complications. Your doctor will determine if these conditions apply to you, but some are determined by your case history.

If you have both types of insurance plans:

1. Vision care plan guidelines dictate that medical insurance must be billed as primary if your medical insurance plan includes a routine eye exam.
2. It may be necessary for us to bill some services to one plan and other services to the other. We will use coordination of benefits to do this properly and to minimize your out-of-pocket expense.
3. We will bill your insurance plan for services if we are a participating provider for that plan. We will try to obtain advanced authorization of your insurance benefits so we can tell you what is covered. If some fees are not paid by your plan, we will bill you for any unpaid deductibles, co-pays or non-covered services as allowed by the insurance contract.

I have read and agree with the above policies.

_____ _____

Patient signature (parent if child) Date

Visions Eye Care + Therapy Center
6201 S. Minnesota Ave.
Sioux Falls, SD 57108
(605) 274-6717 and (605) 271-7100

ACKNOWLEDGMENT: RECEIPT OF NOTICE OF PRIVACY PRACTICES

Adult Patient

I have been offered and/or received a copy of Visions Eye Care + Therapy Center's Notice of Privacy Practices.

Name (please print): _____

Signature: _____

Date: _____

Child Patient

I am a parent or legal guardian of _____ (patient name). I have been offered and/or received a copy of Visions Eye Care + Therapy Center's Notice of Privacy Practices.

Name (please print): _____

Relationship to Patient: ☐ Parent ☐ Legal Guardian

Signature: _____

Date: _____

FOR VISIONS USE ONLY:

If the individual or parent/legal guardian did not sign above, staff must document when and how the Notice was given to the individual, why the acknowledgment could not be obtained, and the efforts that were made to obtain it.

Notice of Privacy Practices given to individual on _____ (date)

☐ In Person ☐ Mailing ☐ Email ☐ Other _____

Reason individual or parent/legal guardian did not sign this form:

☐ Did not want to
☐ Did not respond after more than one attempt
☐ Other _____

The following good faith efforts were made to obtain the individual or parent/legal guardian's signature. Please document with dates, times, individuals spoken to, and outcome, as applicable, the efforts that were made to obtain the signature. More than one attempt must be made.

☐ In person conversation _____
☐ Telephone contact _____
☐ Mailing _____
☐ Email _____
☐ Other _____

Staff Name (please print): _____ Title: _____

Signature: _____