VSP
WELL VISION LEARNING SOURCE

Dr. Robert Zoellner and Associates
Welcome To Our Office

APPT: ____ WI: ___
NP / PP - GL / CL

Welcome to Dr. Robert Zoellner and Associates. Thank you for choosing us for your eyecare 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. Any information we already have on file will appear on this form. Please review all completed areas to ensure that the information we have is current and accurate. 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

How were you referred to our office?

Current Occupation :

☐ Phone Book ☐ School ☐ Advertisement ☐ Patient
☐ Insurance Listing ☐ Drive by ☐ Other ☐ Doctor

VISION INSURANCE INFORMATION

M ☐ F ☐

Insured's First Name | MI | Insured's Last Name

Insureds Address | City | State | Zip

Insured's Social Security # | Insured's Place of Employment

Name of Vision Insurance Company | City | State | Zip

Insured's Identification Number | Group Number | Insured's Date of Birth

Patient Relationship to Insured
☐ Self ☐ Spouse ☐ Child ☐ Other

Patient Status
☐ Single ☐ Married ☐ Other
☐ Full Time Student ☐ Part Time Student ☐ Employed

PATIENT HISTORY AND INFORMATION

What is the main reason for today's exam ? _____ When was your last exam ? _____

Past Eye Surgeries: _____

Current Medications: _____

HEALTH HISTORY _____

Current Eye Drops: _____

_____

Medicines that cause reactions or sensitivities: _____

Specific Allergies: _____

Name **del**

EYE HISTORY

Glaucoma	○ Yes ○ No	Dryness	○ Yes ○ No	Strabismus (Crossed Eyes)	○ Yes ○ No
Cataract	○ Yes ○ No	Excess Tearing/Watering	○ Yes ○ No	Blurred Vision Distance	○ Yes ○ No
Macular Degeneration	○ Yes ○ No	Eye Pain or Soreness	○ Yes ○ No	Blurred Vision Near	○ Yes ○ No
Retinal Detachment	○ Yes ○ No	Foreign Body Sensation	○ Yes ○ No	Distorted Vision (halos)	○ Yes ○ No
Color Blindness	○ Yes ○ No	Infection of Eye or Lid	○ Yes ○ No	Double Vision	○ Yes ○ No
Headaches	○ Yes ○ No	Itching	○ Yes ○ No	Floaters or Flashes	○ Yes ○ No
Glare/Light Sensitivity	○ Yes ○ No	Mucous Discharge	○ Yes ○ No	Fluctuating Vision	○ Yes ○ No
Tired Eyes	○ Yes ○ No	Drooping Eyelid	○ Yes ○ No	Loss of Vision	○ Yes ○ No
Amblyopia (Lazy Eye)	○ Yes ○ No	Redness	○ Yes ○ No	Loss of Side Vision	○ Yes ○ No
Burning	○ Yes ○ No	Sandy or Gritty Feeling	○ Yes ○ No	Flashes of Light	○ Yes ○ No

GENERAL HEALTH CONDITION

Fever	○ Yes ○ No	Respiratory (Asthma)	○ Yes ○ No	Anxiety or Depression	○ Yes ○ No
Weight Loss	○ Yes ○ No	Gastrointestinal	○ Yes ○ No	Thyroid, Diabetes	○ Yes ○ No
Other Symptoms	○ Yes ○ No	Kidney	○ Yes ○ No	Blood/Lymph	○ Yes ○ No
Ears,Nose,Throat	○ Yes ○ No	Muscles,Bones,Joints	○ Yes ○ No	Allergic	○ Yes ○ No
Cardiovascular (high blood pressure etc.)	○ Yes ○ No	Skin	○ Yes ○ No	Are you?	☐ Pregnant ☐ Nursing
		Neurological (Multiple Sclerosis)	○ Yes ○ No		

FAMILY HISTORY

Amblyopia (Lazy Eye)	○ Yes ○ No	Retinal Detachment	○ Yes ○ No	High Blood Pressure	○ Yes ○ No
Blindness	○ Yes ○ No	Strabismus (Eye Turn)	○ Yes ○ No	Kidney Disease	○ Yes ○ No
Cataract(s)	○ Yes ○ No	Arthritis	○ Yes ○ No	Lupus	○ Yes ○ No
Color Blindness	○ Yes ○ No	Cancer	○ Yes ○ No	Stroke	○ Yes ○ No
Glaucoma	○ Yes ○ No	Diabetes	○ Yes ○ No	Thyroid Disease	○ Yes ○ No
Macular Degeneration	○ Yes ○ No	Heart Disease	○ Yes ○ No	Others	○ Yes ○ No

MEDICAL HISTORY QUESTIONAIRE

SOCIAL HISTORY

Do you drink alcohol ? If yes, how much/often : ○ No ○ Occasional ○ 1 Per Day ○ 2-3/day ○ 4+/day

Do you smoke ? If yes, how much/often : ○ No ○ Occasional ○ 1/2 pack/day ○ 1 pack/day ○ 1+ pack

Method of Tobacco Intake : ○ Smoking ○ Chewing

Any History of tobacco, alcohol or substance abuse? _____

In order to control the cost of billing, we ask that the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. We would rather control billing costs than be forced to raise our fees. All professional services and material are charged to the patient.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.

Payment from my insurance is to be paid directly to . I understand that will be billed as my primary insurance. I understand that billing any secondary insurance is my responsibility. 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.

_____ _____

Signature Date

VISUAL FIELDS, RETINAL PHOTOGRAPHS AND/OR DILATION

Dr. Robert H. Zoellner strongly recommends that all of our patients receive a visual field test, retinal photographs and/or dilation as a part of our comprehensive visual analysis.

A highly sophisticated computerized instrument now enables us to provide a more thorough visual field screening. This instrument checks for loss of sight, both in central and peripheral areas. Visual field testing can assist us in early detection of glaucoma, retinal problems, some neurological diseases (such as brain tumors and optic nerve disease), and better enables us to diagnose causes of headaches. The fee is $20.00.

While routine retinal photographs and/or dilation of the eye is recommended at least every two years, if you have a condition such as diabetes, cataracts, high blood pressure, headaches, high nearsightedness, symptoms of flashing lights or floaters, glaucoma or a family history of glaucoma, you are urged to have retinal photographs and/or dilation today. Dilation involves placing drops in your eyes to enlarge your pupil size. Photographs of the retina give our doctors a more extensive view of the posterior section of the eye.

When an eye is dilated, we are able to get a much broader and fuller view of the inside of the eye. This aids us in determining diseases (such a macular degeneration, glaucoma and tumors), damage to the retina (such as holes or tears) and evaluation of cataracts.

With dilation of the eyes you may experience the following effects:

1) increased sensitivity to light
2) a slight blurring of distance vision
3) inability to focus up close

These effects typically last from 4-8 hours. The fee for this test is $20.00

Please Note:

- Visual fields show us how the retina functions.
- Retinal photographs and/or dilation broaden the view of the back of the eye.
- All are equally important.

Please check one of the following and sign below:

_____ I do consent to only the visual fields for $20.00.

_____ I do consent to only the retinal photographs and/or dilation for $20.00.

_____ I do consent to having visual fields, retinal photographs and/or dilation. The fee for both is reduced from $40.00 to $35.00.

_____ I do understand the importance of visual field testing, retinal photographs and/or dilation, yet I do not wish to have either performed at this time. I release Dr. Robert H. Zoellner from any liabilities related to the failure to treat or diagnose any eye conditions due to the lack of diagnostic information which could have been obtained by these tests.

_____ _____

(Patient's Signature or Guardian) Date

Patient Consent Form

I understand that under the Health Insurance Portability Accountability Act of 1966 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can be used to:

*Conduct, plan and direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly or indirectly.

*Obtain payment from third-party payers.

*Conduct normal healthcare operations such as quality assessment and physician certifications.

I have been informed by your office of your *Notice of Privacy Practices* containing a more completed description of the uses of my health information. I have been given the right to review such *Notice of Privacy Practices* from time to time and know that I may contacts this organization at any time to obtain a current copy of *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand that you are not required to agree to my requested restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____ Date: _____

Patient Signature: _____

If patient cannot sign or is a minor, please sign below and indicate relationship to patient

Patient Name: _____ Date: _____

Patient Signature: _____