VISION SOURCE
The Family Eye Site

Dr. Caleb Kennedy • Optometric Physician

Today's Date _____

Patient Information

Last _____
First _____ MI _____
Address _____
City _____ State _____
Zip Code _____
Home Phone _____
Cell Phone _____
Work _____
Patient's SSN _____
Employer (or School) _____
Occupation (or Grade) _____
Spouse (or Parent's) Name _____
DOB: Mo_____ Day_____ Yr_____
Sex M F
E-mail_____@_____
What is the major purpose of this visit?

_____
_____

Any problems with your current contact lenses or glasses?

_____
_____

VERY IMPORTANT! NEW PATIENTS ONLY:
Who may we thank for referring you to our office?
Name of friend or relative _____
If not referred, how did you choose our office?
__ Another Dr.
__ Our City Magazine
__ Insurance List
__ Saw Sign/Building
__ Newspaper/Radio/TV
__ Yellow Pages: Which directory? _____
__ Web Page: Which Website? _____
__ Other _____

At the Family Eye Site, we are committed to treat our patients as we would our family and friends...with respect and a caring attitude. We are devoted to our profession by providing the highest level of quality eye care to each patient. We are dedicated to raise the awareness of the importance of vision and how it affects their lives and future.

Insurance Information

Vision Insurance _____
Subscriber Name _____
Subscriber SSN _____
Subscriber Birth Date / /

Primary Medical Insurance _____
Subscriber Name _____
Subscriber SSN _____
Subscriber Birth Date / /

Do you participate in a flex spending account?
__ YES __ NO
How will you settle your account today?
__ Cash __ Credit Card

Lifestyle Questions

Do you.....(check box if your answer is yes)
__ work at a computer?
__ think you might benefit from thinner, lighter lenses?
__ what are your hobbies? _____
__ what is your occupation? _____
__ get bother by glare from on-coming headlights while driving at night?
__ prefer not to wear your glasses at times?
__ want information on Laser Vision Correction surgery?
__ have interest in a non-surgical approach to vision correction?
__ have more than 1 pair of current Rx eyewear?
__ have children?
__ have family members in need off eyecare?

Have you ever experienced, been diagnosed or treated for any of the following?

__ Blurry Vision
__ Cataracts
__ Crossed eye
__ Eye Infections
__ Flash of Lights
__ Glaucoma
__ Headaches
__ Itchiness
__ Macular Degeneration
__ Retinal Detachment
__ Tearing
__ Uncomfortable glasses
__ Other eye disorders_____
__ Burning
__ Corneal Abrasions
__ Double Vision
__ Eye Injury
__ Floaters/Spots
__ Grittiness
__ Iritis/Uveitis
__ Lazy Eye
__ Occasional dryness
__ Sunlight Sensitivity
__ Trouble seeing at night

The information in this confidential case history form is critical to the evaluation of your vision and health

Patient Medical History	**Patient Eye History**
Name of Family Physician _____	Date of Last Eye Exam / /
City _____	By Whom? _____
Date of Last Physical Check-Up / /	Have you ever tried contact lenses? __ Yes __ No
	Do you wear contact lenses? __ Yes __ No
CURRENT MEDICATIONS (Rx or over the Counter) _____	What kind? _____
_____	Solutions used _____
	Are you satisfied with the vision and comfort of your contact lenses? __ Yes ___ No
Allergies to medications? __ Yes __ No	Would you prefer clear contact lenses or colored contact lenses? __ Yes __ No
If so, what medications?	If you wear bifocals, do the lines or head tilting bother you? __ Yes __ No
_____	
_____	
Do you use: Cigarettes or tobacco? __ Yes __ No	**Family Medical/Eye History (Check all that apply)**
Alcohol? __ Yes __ No	Is there a family medical history of any following: (Mother's or Father's side)
Other substances? __ Yes __ No	
Have you ever been diagnosed or treated for the following health problems?	
__ Allergies __ Throat Infections	High Blood Pressure ▫_____
__ Blood/Lymph __ Weight loss/gain	Diabetes ▫_____
__ Cancer __ Arthritis	Blindness ▫_____
__ Diabetes __ Bronchitis	Cataracts ▫_____
__ Ears/Nose/Throat __ Cholesterol	Glaucoma ▫_____
__ Eczema/Rashes __ Digestive	Corneal Problems ▫_____
__ Fevers __ Endocrine	Heart Disease ▫_____
__ High Blood Pressure __ Genitourinary	Lazy Eye ▫_____
__ Kidney __ Thyroid	Macular Degeneration ▫_____
__ Neurological __ Muscle/Bone	Retinal Problems ▫_____
__ Respiratory __ Sinus	

I authorize Dr. Caleb J. Kennedy to release any information including the diagnosis, examination and treatment records for me during the period of care to my third-party payer or insurance company. I understand insurance may only cover part of my incurred charges. If my insurance is not accepted, I agree to pay Dr. Caleb J. Kennedy and will be responsible for filing my own insurance claim. If my insurance does not pay as expected, I am ultimately responsible for all my charges. I understand that The Family Eye Site may contact me letting me know when contacts, glasses, supplies are ready and this may include communication by e-mail, text messages, and/or newsletters.

Signature _____

Relationship (if patient is a minor)

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Please check off the appropriate column for each problem that occurs for this child

	Often Occurs	Sometime Occurs	Never Occurs
Signs of Eye Teaming Problems	✓	✓	✓
Covers or closes one eye when reading			
Rubs eyes			
Child complains of eyestrain			
Child complains of headaches			
Child complains of double vision			
Child complains of words moving on the page			
Inattentive			
Poor reading comprehension			
Loses place when reading			
Signs of Focusing Problems			
Child complains of blurred vision			
Child complains of blurred vision when looking from desk to board			
Child complains of eyestrain			
Child complains of headaches			
Rubs eyes			
Poor reading comprehension			
Is tired at the end of the day			
Holds things very close			
Signs of Tracking Problems			
Loses place often			
Must use finger or guide to keep place			
Skips lunes ad words often			
Poor reading comprehension			
Short attention span			
Signs of Visual Processing Disorders			
Trouble learning left to right			
Reverses letters and numbers			
Mistakes words with similar beginnings			
Can't recognize the same word repeated on a page			
Trouble learning basic math concepts of size, magnitude			
Poor reading comprehension			
Poor recall of visually presented material			
Trouble with spelling and sight vocabulary			
Sloppy writing skills			
Erases excessively			
Can respond orally but not in writing			
Seems to know material but does poorly on written tests			

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www.FamilyEyeSite.com Email: DrKennedy@FamilyEyeSite.com

Receipt of Notice of Privacy practices
Written Acknowledgement

I, _____, have reviewed/received a copy of **Caleb Kennedy, O. D's** Notice of privacy
Patient Name
Practices.

Signature _____ Date _____

Relationship if patient is minor_____

Office Use Only

I attempted to obtain the patients signature in acknowledgement of this Notice of Privacy Practices

Acknowledgement, but was unable to do so as documented below:

Date_____ Initials_____ Reason: _____

Consent to Share Medical Information

I give permission to share medical information with the person(s) named below:

Name _____

Name _____

Primary Care Physician _____

I may revoke this permission at any time when provided in writing to this office.

_____ _____
Print Patient Name Date

_____
Signature

Relationship if patient is a minor _____

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Office Financial Policy

Thank you for choosing Vision Source-The Family Eye Site, the office of Dr. Caleb Kennedy. Our goal is to deliver the best and most comprehensive vision care available. An important part of that goal is to make the cost of optimal care as easy and manageable as possible for our patient by offering several payment options.

Payment Options:

You can choose from:

- **Cash, Visa, Mastercard, American Express or Discover.**
- **No Interest*Payment Plans**from Care Credit**
  - **Allow you to pay for 6 months with no interest**
  - **Convenient, low monthly payment plan**available**
  - **No annual fees of prepay-payment penalties.**

Payment Policies:

Payment is required at the time of your examination.

Materials ordered (contacts lenses, prescription and non-prescription eyewear) require a minimum 50% payment to process order. Payment in full is gladly accepted. Materials ordered with a 50% deposit is required to be picked-up and paid in full within 30 days of notification from our office that the item is ready. Orders not picked up after 30-day notification, are subject to cancelation without refund of deposit.

All co-payments for insurance covered services are to be paid at the time of service.

For patients with vision insurance we are happy to work with your plan to maximize your benefits and directly bill them for the services and/or products that you ordered.

However, if we do not receive payment from your insurance carrier within 60 days, you will be responsible for payment for those services and products billed and collection of your benefits directly from your insurance carrier. Services billed to insurance and not covered by your plan will be billed to you. Payment required upon receipt of statement.

Eyeglasses ordered through vision plans are processed electronically within a few hours, once ordered with the insurance laboratory, we are unable to cancel. Should you need to cancel after the order has been placed, there is a 50% cancelation charge.

If you have any questions, please do not hesitate to ask. We are here to help you.

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please print)

*If paid within the promotional period. Otherwise, interest assessed from purchase date. Minimum monthly payment required.

**Subject to credit approval