PATIENT UPDATE FORM

First, MI, Last, Preferred Name

Street Address

City, State, Zip

Phone, Type Phone 2, Type

Email Preferred Contact Method Phone 1 | Phone 2 | Email | Text

Date of Birth

Occupation/Employer full-time | part-time

Marital Status Married | Single | Divorced | Legally Separated | Widowed

Primary Language, Race, and Ethnicity I refuse to disclose this info (initial here) ☐

Mother's Name / Birthday / Primary Phone Number:

Father's Name / Birthday / Primary Phone Number:

Family Members / Siblings:

Do you currently take any medications, vitamins, herbs? Yes | No **(We can scan your list if you have it!)**

Are you allergic to any medications? Yes | No **If yes, please list below:**

Height: **Weight:** I refuse to disclose this info (initial here) ☐ **Are you pregnant or nursing?** Yes | No

Do you use tobacco products? Yes | No **If yes, what kind/how much/how long?**

If no, did you ever? Yes | No

Do you want to select new eyewear today? Yes | No | If needed

Do you wear sun protection? Yes | No | I don't have light sensitivity

Do you have backup glasses? Yes | No If yes, how old is the prescription?

Do you wear contacts? Yes | No | I tried in the past, but they didn't work out

Would you consider trying contacts again? Yes | No | If there are new options available

Do you have any specific concerns you'd like us to address today? Yes | No **If yes, please describe them below**

OFFICE POLICIES

1. Payment for services is expected at the time the service is rendered. Glasses and/or contact lenses will be ordered after half down of product total is received in our office and must be paid in full before they can leave our office. We are happy to discuss payment plans if you have a need.
2. Please present all insurance cards to our receptionist at each visit so we can verify coverage and benefits. Authorization and Assignment: I hereby authorize the release of medical information to my insurance company and assign to Vision Care PSC and Dr. Matt Hesse all payment for services rendered to me or my dependents. This assignment will remain in effect until revoked by me in writing. A copy of this authorization may be used in place of the original. Insurance claims will be filed only if our office is a participating provider for my plan; however, it is my responsibility to know my covered benefits. Should my insurance not reimburse the office in a timely manner, I am responsible for the balance.
3. In accoradance with KY State Law, eyeglass prescriptions are valid for two (2) years. In order to protect the health of your eyes and in accordance with KY State Law, contact lens prescriptions are valid for one (1) year only.
4. The undersigned agrees that if this account is not paid when due, and this office should retain an attorney or collection agency for collection, the undersigned agrees to pay all costs of collection including court costs, reasonable interest, reasonable attorney's fees and reasonable collection agency fees.

If you have any questions concerning any of the above policies, please see the receptionist for further explanation. **Additionally, I acknowledge that I have had the opportunity to review the notice of privacy practices for Vision Care.**

(Sign) _____ (Date) _____