Dr. Tom MacMillan
Dr. Jeremy Anderson
Dr. David MacDonald
Dr. Lindsay Wood

Spartanburg VISION

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Spartanburg, SC 29301
(864) 576-0564
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*Our **vision** is to protect **yours***

Date: ____ / ____ / ____

Name: Last _____ First _____ M.I. _____ Preferred Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home / Mobile Phone: _____ Texting Okay? Y / N Work Phone: _____

Date of Birth: _____ / _____ / _____ Age _____ Male / Female SS#: _____

Marital Status: ☐ Single ☐ Married ☐ Other _____Race: Asian / Black / Hispanic / White / Other _____

Employer: _____ Occupation: _____ Email: _____

How were you referred to our office? _____

Who is the insurance policy holder?

☐ Self ☐ Other: Insured's Name: _____ Insured's DOB: ____ / ____ / ____

Insured's SSN: _____ Relationship to patient: _____

Name of Primary **Medical** Insurance Carrier: _____ ID #_____

Name of Secondary **Medical** Insurance Carrier: _____ ID # _____

Name of **Vision** Insurance Carrier: _____ ID # _____

~ You will be responsible for any portion of your bill which is not paid for by your insurance company.~

Eye History

Why did you schedule your visit today? _____

Do you wear glasses? Yes / No / Full-time / Part-time / Distance Only / Near Only

Do you currently wear contacts? Yes / No / Clear / Color Brand _____

Do you want to be fitted for contacts today? Yes / No / Clear / Color

Please check any of the following that apply

☐ Blurry Distance Vision	☐ Dry Eyes	☐ Headaches	☐ Glaucoma
☐ Blurry Near Vision	☐ Red Eyes	☐ Migraine Headaches	☐ Cataracts
☐ Double Vision	☐ Watery Eyes	☐ Loss of Vision	☐ Macular Degeneration
☐ Eye Strain	☐ Wandering Eye	☐ Crossed Eyes	☐ Retinal Disease
☐ Eye Infection	☐ Mucous Discharge	☐ Light Sensitive	☐ Blindness
☐ Eye Pain / Soreness	☐ Floaters or Spots	☐ Sandy/Gritty Feeling	☐ Prosthetic Eye
☐ Tired Eyes	☐ See Flashes	☐ Poor Color Vision	
☐ Burning Eyes	☐ See Halos	☐ Droopy Lid	☐ None
☐ Itchy Eyes	☐ Poor Night Vision	☐ Glare or Reflection	

Please complete other side

Patient Name: _____ Date: ____ / ____ / ____

Date of Last Eye Exam: _____ Where did you get your last exam? _____

Date of Last Physical/Medical Exam: _____ Name of Medical doctor: _____

Personal Medical History (Review of Systems)

Please check if any of the following applies to you.

Cardiovascular: ☐ None
- ☐ Hypertension
- ☐ Stroke
- ☐ Heart Disease
- ☐ Vascular Disease
- ☐ Other _____

Endocrine: ☐ None
- ☐ Non-Insulin Dependent Diabetes
- ☐ Insulin Dependent Diabetes
- ☐ Thyroid Problem
- ☐ Hormonal Dysfunction
- ☐ Other _____

Respiratory: ☐ None
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ COPD
- ☐ Other _____

Constitutional: ☐ None
- ☐ Weight loss/gain
- ☐ Fatigue
- ☐ Blackouts
- ☐ Other _____

Psychiatric: ☐ None
- ☐ ADHD
- ☐ Depression
- ☐ Schizophrenia
- ☐ Other _____

Ear/Nose/Throat: ☐ None
- ☐ Hearing Loss
- ☐ Upper Respiratory Infection
- ☐ Sinus Infection
- ☐ Other _____

Neurological: ☐ None
- ☐ Multiple Sclerosis
- ☐ Epilepsy
- ☐ Cerebral Palsy
- ☐ Tumor
- ☐ Other _____

Musculoskeletal: ☐ None
- ☐ Osteoarthritis
- ☐ Fibromyalgia
- ☐ Muscular Dystrophy
- ☐ Ankylosing Spondylitis
- ☐ Other _____

Immunologic: ☐ None
- ☐ AIDS or HIV
- ☐ Rheumatoid Arthritis
- ☐ Lupus
- ☐ Neurofibromatosis
- ☐ Other _____

Hematological: ☐ None
- ☐ Anemia
- ☐ Leukemia
- ☐ Sickle Cell Disease
- ☐ Other _____

Gastroinstestinal: ☐ None
- ☐ Chron's
- ☐ Colitis
- ☐ Acid Reflux
- ☐ Other _____

Dermatologic: ☐ None
- ☐ Eczema
- ☐ Rosacea
- ☐ Psoriasis
- ☐ Other _____

Genitourinary: ☐ None
- ☐ Bladder Infections
- ☐ Sexually Transmitted Disease
- ☐ Other _____

Tobacco Products: ☐ Never Smoked
- ☐ Former Smoker
- ☐ Current daily smoker
- ☐ Current occasional smoker

Alcohol Use: ☐ None
- ☐ Social Use
- ☐ Daily Use
- ☐ Dependency

Medication Allergies: _____ Other Allergies: _____

Please list all medications currently taken: _____

Please list any major surgeries: _____

Current Height: _____ Current Weight: _____

Family History

Disease/Condition	Relationship	Disease/Condition	Relationship
Glaucoma:	Yes/No _____	High Blood Pressure:	Yes/No _____
Macular Degeneration:	Yes/No _____	Diabetes:	Yes/No _____
Retinal Detachment:	Yes/No _____	Cancer:	Yes/No _____
Blindness:	Yes/No _____	Heart Disease:	Yes/No _____
Crossed Eyes:	Yes/No _____	Thyroid Disease:	Yes/No _____

Authorization for Release of Information

This form authorizes Spartanburg Vision to release protected information about the patient named below to the people listed (e.g. spouse, parent, sibling) by means of phone calls and voice mails/answering machine messages.

I consent to the release of (please check all that apply):

- ☐ Financial/Billing Information
- ☐ Medical Care (treatments plans, medications, procedures, appointments, test results, etc.)

This information may be released to the following:

- ☐ Patient's voice mail/answering machine
- ☐ Voice mail/answering machine of (e.g. spouse, parent sibling):

_____ _____
Name/Relationship to patient Phone

_____ _____
Name/Relationship to patient Phone

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in the document by sending a written notification to Spartanburg Vision. I understand that a revocation is not effective in cases where the information has already been disclosed.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned upon signing. This authorization shall be in effect until revoked by the patient.

X_____
Signature of Patient (parent or legal guardian if minor)

Notice of Privacy Practices

Spartanburg Vision will provide me a copy of their Notice of Privacy Practices upon request. _____
(Please Initial)

Statement of Financial Responsibility and Assignment of Insurance Benefits

I understand that I am financially responsible for all charges not paid by insurance. I authorize the release of information to my insurance company for insurance/medical purposes. I hereby authorize payment from my insurance company to MacMillan Optical.

X_____ _____ _____
Signature of Patient (legal guardian if minor) Print Name Date