First Street Vision

1940 East 1st Street
Casper, WY 82601

(307) 266-9988 phone
(307) 266-9992 fax

Welcome to our Office!

Date: _____

Name: _____ Date of birth: _____

SSN: _____

Parent/guardian name if patient is a minor: _____

Address: _____

Phone: _____May we leave confidential messages (test results, etc.) at this number? ☐ Yes ☐ No

May we send a text message to this number to remind you of your appointment: ☐ Yes ☐ No

Email address: _____Can we contact you via email? ☐ Yes ☐ No

Occupation/employer:_____ Work phone: _____

Vision insurance:_____ Medical insurance: _____

Is any other family member a patient in our office? _____

Who may we thank for referring you? _____

Who is responsible for payment of services? _____

Payer's phone number (if different from the patient): _____

Payer's address (if different from the patient): _____

Name of medical doctor: _____ Date of last exam: _____

Main reason for visit today: _____

Do you wear glasses? ☐ Yes ☐ No If yes, how old are your lenses?: _____

Do you wear contacts? ☐ Yes ☐ No If yes, what type and how old are your lenses?: _____

Are you interested in: ☐ glasses ☐ laser vision correction ☐ vision therapy/rehabilitation

☐ contacts ☐ corneal reshaping ☐ eye health nutritional supplements

Do you have any allergies to medications? ☐ Yes ☐ No

If yes, explain_____

Do you have any other allergies (environmental/seasonal)? ☐ Yes ☐ No

If yes, explain_____

Please list medications currently taken:_____

Do you use tobacco products? ☐ Yes ☐ No If yes, type/amount/how long: _____

Do you drink alcohol? ☐ Yes ☐ No If yes, type/amount/how long: _____

Do you use illegal drugs? ☐ Yes ☐ No If yes, type/amount/how long: _____

Are you currently pregnant? ☐Yes ☐ No Are you currently nursing? ☐ Yes ☐ No

Medical History (personal and family)

OCULAR

Crossed Eyes	☐ Self	☐ Family	relationship to you: _____
Lazy Eye	☐ Self	☐ Family	relationship to you: _____
Cataract	☐ Self	☐ Family	relationship to you: _____
Glaucoma	☐ Self	☐ Family	relationship to you: _____
Macular Degeneration	☐ Self	☐ Family	relationship to you: _____
Retinal Disease	☐ Self	☐ Family	relationship to you: _____
Other: _____	☐ Self	☐ Family	relationship to you: _____

Have you ever had any type of eye injury or eye surgery? ☐ Yes ☐ No

If yes, explain: _____

CARDIOVASCULAR

Heart Disease	☐ Self	☐ Family	relationship to you: _____
High Blood Pressure	☐ Self	☐ Family	relationship to you: _____
Heart Attack	☐ Self	☐ Family	relationship to you: _____
Stroke	☐ Self	☐ Family	relationship to you: _____

ENDOCRINE

High Cholesterol	☐ Self	☐ Family	relationship to you: _____
Diabetes	☐ Self	☐ Family	relationship to you: _____
Kidney Disease	☐ Self	☐ Family	relationship to you: _____
Thyroid Disease	☐ Self	☐ Family	relationship to you: _____

GASTROINTESTINAL

GERD	☐ Self	☐ Family	relationship to you: _____
Crohn's Disease	☐ Self	☐ Family	relationship to you: _____
Liver Disease	☐ Self	☐ Family	relationship to you: _____

HEMATOLOGIC/LYMPHATIC

Anemia	☐ Self	☐ Family	relationship to you: _____
Clotting Disorder	☐ Self	☐ Family	relationship to you: _____
Sickle Cell	☐ Self	☐ Family	relationship to you: _____

IMMUNOLOGIC

Herpes Simplex	☐ Self	☐ Family	relationship to you: _____
Herpes Zoster	☐ Self	☐ Family	relationship to you: _____
HIV/AIDS	☐ Self	☐ Family	relationship to you: _____
Sarcoidosis	☐ Self	☐ Family	relationship to you: _____

RESPIRATORY

Asthma	☐ Self	☐ Family	relationship to you: _____
Cystic Fibrosis	☐ Self	☐ Family	relationship to you: _____
Emphysema	☐ Self	☐ Family	relationship to you: _____

M**USCULOSKELETAL**

Arthritis	☐ Self	☐ Family	relationship to you: _____
Ankylosing Spondylitis	☐ Self	☐ Family	relationship to you: _____
Myasthenia Gravis	☐ Self	☐ Family	relationship to you: _____

SKIN

Rosacea	☐ Self	☐ Family	relationship to you: _____

NEUROLOGICAL

Headache/Migraine	☐ Self	☐ Family	relationship to you: _____
Acquired Brain Injury	☐ Self	☐ Family	relationship to you: _____
Multiple Sclerosis	☐ Self	☐ Family	relationship to you: _____

PSYCHIATRIC

Attention disorder	☐ Self	☐ Family	relationship to you: _____
Alzheimer's	☐ Self	☐ Family	relationship to you: _____
Depression	☐ Self	☐ Family	relationship to you: _____

Please list any other condition(s) you have that are not found above:

_____

PAYMENT POLICY

As a courtesy, we file Medicare, Medicaid, Vision Service Plan (VSP)/Cigna, CHIP, Blue Cross/Blue Shield, GEHA, Meritain, and Tricare. Other insurance plans are the patient's responsibility to file. Please inform us of any medical or vision insurance coverage before your exam, so we can verify benefits and coverage at the time of service. Verification of coverage is not a guarantee of payment from your insurance company.

Payment is due at the time of service and before glasses or contacts can be ordered**.** This includes all insurance co-pays. If needed, we accept half down with the remaining balance due before the glasses or contact lenses can be dispensed. In the event of non-payment to First Street Vision, a $6.00 billing fee per month will be assessed. Accounts that are assigned to an agent for collection will additionally be assessed a 35% fee on any unpaid balance.

Signature: _____ Date: _____