Boerne Vision Center

WELCOME TO OUR OFFICE!

Date _____ Patient ID _____ Date of Birth _____ Gender _____

Salutation _____ First Name _____ MI _____ Last Name _____

Mailing Address _____ City, State, Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____ E-mail (will not be shared) _____

Preferred Method of Contact: (circle one) **Home** **Work** **Cell** **E-mail**

Person Holding The Patient's Insurance Policy (if other than patient): _____ **DOB** _____

Social Security Number (required for insurance) _____ **Emergency Contact:** _____ Name _____ Phone

_____ Relationship

Guardian's Name (if patient is a child) _____ **Race (circle one):** ASIAN BLACK NATIVE AMERICAN PACIFIC ISLANDER WHITE OTHER 2 OR MORE **Ethnicity: (circle one)** HISPANIC NOT HISPANIC

How were you referred to our office?

__ Phone Book __ Advertisement __ Patient _____
__ Internet __ School
__ Insurance Listing __ Other __ Doctor JENNIFER JOHNSON, OD

Occupation _____ **Do you use a computer?** ____ Hour(s) ____ Day(s)

Primary Care Physician _____ City _____ Phone Number _____

Medical Information:

Height ___ ft ___ in Weight _____ lbs

Past Injuries / surgeries / major illnesses: _____

Ocular History (including eye diseases, eye surgeries, eye conditions): _____

Are you currently pregnant? ___ Yes ___ No

When was your last eye exam? _____

Do you currently wear glasses? ___ Yes ___ No

Contact Lenses? ___ Yes ___ No

Family Medical History: Note relation to the patient (ex: "Mother", "Paternal Grandfather", etc.)

___ Macular Degeneration _____ ___ Cancer _____
___Cataract _____ ___ Diabetes _____
___Glaucoma _____ ___ Heart Disease _____
___ Blindness _____ ___ Hypertension _____
___ Other Ocular Disease_____ ___ Stroke _____
___Migranes _____ ___ Sickle Cell _____

Please answer the following relating to the patient:

Smokes or uses tobacco? ___ Every Day ___ Some Days ___ Former Smoker ___ Never Smoked

Drinks Alcohol? ___ Yes ___ No How Often _____

Illegal Drugs? ___ Yes ___ No

Drives? ___ Yes ___ No At Night? _____

Current Allergies: _____

Current Medications (including prescription, over the counter, vitamins, supplements, and eye drops):_____

_____

Review of Systems: (please check all that apply to the patient)				
Eyes ___ Vision Loss ___ Blurry Vision ___ Distorted Vision ___ Double Vision ___ Dryness ___ Redness ___ Mucus Discharge ___ Itching ___ Burning ___ Watering ___ Light Sensitivity ___ Eye Pain/Soreness ___ Chronic Infection ___ Bumps on Lids ___ Flashes ___ Floating Spots	___ Tired Eyes ___ Cataracts ___ Diab. Retinopathy ___ Glaucoma ___ Macular Degen. ___ Retinal Detachment **Gastrointestinal** ___ Colitis ___ Crohn's ___ Ulcers ___ Constipation ___ Diarrhea **Constitutional** ___ Fever ___ Fatigue ___ Trauma	**Skin** ___ Eczema ___ Rosacea ___ Psoriasis **Neurologic** ___ Headaches ___ Migraines ___ Seizures ___ Multiple Sclerosis **Ear/Nose/Throat** ___ Allergies ___ Sinus Congestion ___ Runny Nose ___ Chronic Cough ___ Dry Throat/Mouth **Respiratory** ___ Asthma ___ Bronchitis ___ Emphysema	**Cardiovascular** ___ Heart Disease ___ Hypertension ___ High Cholesterol **Allergic/Immune** ___ Drug Allergies ___ Seasonal Allergies ___ Lupus ___ Arthritis **Endocrine** ___ Non-Insulin Diab. ___ Insulin Diabetes ___ Thyroid Dysfunction ___ Hormonal Dysfunction	**Musculoskeletal** ___ Fibromyalgia ___ Muscular Dystrophy ___ Osteoarthritis ___ Ankylosing Spondylitis **Lymph/Heme** ___ Anemia ___ Bleeding ___ Leukemia **Genitourinary** ___ Kidney Prob ___ Bladder Prob ___ STDs

Please list any other problems you may be experiencing: _____

I hereby authorize the release of any medical information necessary for the procession of insurance. I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled to Dr. Darrell Willerson, Jr., Charles D. Brodrick, M.D., Jennifer Johnson, O.D. (**HERE IN AFTER REFERRED TO AS THE "DOCTOR")** This assignment will remain in effect until revoked by me in writing received by the doctor. A photocopy of this assignment is to be considered as valid as the original.

I hereby authorize the doctor to submit all insurance claims for services or benefits I will receive from the doctor, directly or indirectly, in my name. I agree that my address in such insurance claims will be that of the doctor and hereby order all issuers of insurance claim checks to mail such checks directly to the doctor. I further agree that when the doctor receives any insurance claim check as provided above, I will immediately visit the doctor's office and endorse all insurance claim checks as payable in full to the doctor. The above agreements are made in partial consideration for the services and benefits I will receive from the doctor. However, I will pay for services rendered in the event my insurance company disputes my claim or does not pay in a timely manner.

_____ _____

Signature Date

General Consent

Boerne Vision Center

Dr. Jennifer L. Johnson

Dilation	Yes	No
Ocular Coherence Tomography	Yes	No
Visual Field Testing	Yes	No
Pachymetry	Yes	No
Gonioscopy	Yes	No
Ocular Photography	Yes	No
Foreign Body Removal	Yes	No
Epilation of Lashes	Yes	No
Insertion of Punctal Plugs	Yes	No

_____ _____

PATIENT NAME PATIENT SIGNATURE

_____ _____

DR. JENNIFER JOHNSON DATE