Welcome!

320 South Main Street
Verona, WI 53593
www.veronavisioncare.com

Patient Information

Date______________________

Patient's Name ____

Address ____

City______________________________ State_______________Zip ____________________

Home Phone________________________Work Phone ________________________________

Cell Phone________________________ Email Address ______________________________

Patient's Date of Birth ____

Occupation____

Name of Employer ____

Special visual demands (work or hobbies)____

Please list any members of your household who come to our office______________________

____

How did you hear about our office? ☐ Newspaper (list) _______________ ☐ Internet Search

☐ Insurance Listing ☐ Family Member ☐ Radio ☐ Drive By ☐ Other________________

Referred by _____________________________ May we send a thank you note? ☐ Y ☐ N

Insurance Information

Do you have vision care insurance? ☐ Y ☐ N Name____________________________________

Primary Insured Name_____________________DOB____________I.D. Number_______________

Do you have health insurance? ☐ Y ☐ N Name____________________________________

Please note*: Insurance may cover none or only part of your fees. If we do not accept direct payment from your insurance plan, you will pay our office at the time of service and submit your receipt for reimbursement from your insurance company. If your insurance does not pay as expected, you are ultimately responsible for all charges. We will be happy to assist you with your claims. Please give any forms to the receptionist. If you are using insurance: I authorize the release of any medical or other information necessary to process this claim.*

____ ________________________

Signature of Patient (or Guardian if under 18) Date

HIPAA Privacy Act

____________________________ ______________________________ ______________

Print Name Signature of Patient (or Guardian, if under 18) Date

Name:______________________________ Date:____________

Previous eye doctor and last exam date____

When was your last physical?____

Are you pregnant or nursing? ☐ Y ☐ N

Are you considering refractive surgery/LASIK at some time in the future? ☐ Y ☐ N

Have you had a lazy eye or done patching? ☐ Y ☐ N

Do you smoke? ☐ Y ☐ N

Race: ☐ American Indian ☐ Asian ☐ Black or African American

☐ Pacific Islander ☐ Caucasian ☐ Other

Ethnicity: ☐ Hispanic ☐ Not Hispanic

Health History

Height: _______ft ________in Weight: _________lbs

Cardiovascular ☐ No

☐ Heart Disease
☐ Stroke
☐ Vascular Disease
☐ Other

Endocrine ☐ No

☐ Thyroid Dysfunction
☐ Other

Integumentary ☐ No

☐ Eczema
☐ Rosacea
☐ Psoriasis
☐ Other

Gastrointestinal ☐ No

☐ Crohn's
☐ Ulcer
☐ Other

Immunologic ☐ No

☐ Arthritis
☐ Lupus
☐ Other

Musculoskeletal ☐ No

☐ Fibromyalgia
☐ Osteoarthritis
☐ Muscular Dystrophy
☐ Other

Neurological ☐ No

☐ Multiple Sclerosis
☐ Epilepsy
☐ Alzheimers
☐ Parkinsons
☐ Other

Psychiatric ☐ No

☐ Depression
☐ Anxiety
☐ Other

Respiratory ☐ No

☐ Asthma
☐ Emphysema
☐ Other

NOTICE: There is a contact lens evaluation fee in addition to the exam fee.