

This form is to gather information necessary for Oasis Vision Center to have in order for you to receive patient services. Please provide complete and accurate informaton. Incomplete forms will be returned to you for completion prior to leaving the waiting area, which may result in a delay before you see the doctor. If a secton does not apply it may be left blank. In sections that apply to you items in red are required. We sincerely appreciate your cooperation in completing this form. Thank you.

Patient Name		Person Responsible For Payment If Other Than Patient	
Saultation	Mr. Mrs. Ms. Dr.	Saultation	Mr. Mrs. Ms. Dr.
First		First	
Last		Last	
Middle		Middle	
Suffix	(Jr., Sr., II, III, Etc.)	Suffix	
Nickname		Nickname	
Address		Address	
Address line 1		Address line 1	
Address line 2		Address line 2	
City		City	
State		State	
ZIP		ZIP	
Other Information		Other Information	
Date of Birth		Date of Birth	
SSN Last 4		SSN Last 4	
Sex	<input type="checkbox"/> M <input type="checkbox"/> F	Sex	<input type="checkbox"/> M <input type="checkbox"/> F
Patient Status	<input type="checkbox"/> New <input type="checkbox"/> Existing	Oasis Patient	<input type="checkbox"/> Yes <input type="checkbox"/> No
Phone & E-mail		Phone & E-mail	
One phone number is required	Home	Home	
	Work	Work	
	Cell	Cell	
Preferred Phone	<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell	Preferred Phone	<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell
E-mail		E-mail	
Preferred method of contact from us	<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell <input type="checkbox"/> E-mail <input type="checkbox"/> Text	Prefred method of contact from us	<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell <input type="checkbox"/> E-mail <input type="checkbox"/> Text
Language		Employer	
<input type="checkbox"/> English <input type="checkbox"/> Spanish		Employer Name	
<input type="checkbox"/> Other <input type="checkbox"/> Declined to answer		Position	
Additional Information			
Marital Status	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other		
Invite requested for	<input type="checkbox"/> Trunk Show <input type="checkbox"/> Sun Sale		
Product Interest	<input type="checkbox"/> Glasses <input type="checkbox"/> Contact lenses		
	<input type="checkbox"/> Sunglasses <input type="checkbox"/> Other		

Vision Insurance		Medical Insurance	
Insurance Company		Insurance Company	
Policy Holder Information If Other Than Patient		Policy Holder Information If Other Than Patient	
First Name		First Name	
Last Name		Last Name	
Middle		Middle	
Ins. ID or SSN last 4		Ins. ID or SSN last 4	
Relation to Patient		Relation to Patient	
Address line 1		Address line 1	
Address line 2		Address line 2	
City		City	
State		State	
ZIP		ZIP	
Date of Birth		Date of Birth	
Sex	<input type="checkbox"/> M <input type="checkbox"/> F	Sex	<input type="checkbox"/> M <input type="checkbox"/> F
Phone		Phone	
Phone type	<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell	Phone type	<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell
Employer		Employer	
Race		Ethnicity	
<input type="checkbox"/> American Indian or Alaska Native		<input type="checkbox"/> Hispanic or Latino	
<input type="checkbox"/> Asian		<input type="checkbox"/> Not Hispanic or Latino	
<input type="checkbox"/> Black or African American		<input type="checkbox"/> Declined to answer	
<input type="checkbox"/> Native Hawaiian or other Pacific Islander			
<input type="checkbox"/> White			
<input type="checkbox"/> All Other Races			
<input type="checkbox"/> Declined to answer			
Signature of Person Responsible for Payment			

**Minor Age Patients**

Oasis Vision Center requires that a parent or legal guardian accompany all minor patients. The parent or legal guardian that accompanies the minor for services will be responsible for payment.

**All Patients**

It is your responsibility to understand your insurance plan is a contract between you and your insurance company, but not with Oasis Vision Center, P.C. Our office cannot guarantee your insurance will pay, but we will make every attempt before providing you services to verify your policy benefits, if needed retrieve an insurance authorization, and share this information with you. On the condition that we are contracted as a provider with your insurance company we will submit your claim to your insurance company and allow 60 days for your insurance carrier to process and pay the claim. If for some reason your insurance company denies the claim, you are responsible for any amount due on your account immediately. By signing below I accept full financial responsibility.

Signature \_\_\_\_\_

Date \_\_\_\_\_

Patient Name \_\_\_\_\_

Please ✓ all of the conditions you currently have or have a history of.

**Systemic Conditions**

**Constitution**

- Developmental Disability
- Cancer
- Fatigue Syndrome
- Other

**ENT**

- Hearing Loss
- Sinusitis
- Dry Mouth
- Laryngitis
- Other

**Neuro**

- Multiple Sclerosis
- Seasures / Epilepsy
- Cerebral Palsy
- Tumor
- Stroke / CVA
- Migraines
- Autism
- Other

**Psych**

- Depression
- Attention Deficit
- Anxiety / Panic Disorder
- Bipolar Disorder
- Other

**Cardiovascular**

- Hypertension
- Stroke / CVA
- Heart Disease
- Vascular Disease
- Congestive Heart Failure
- Other

**Respiratory**

- Cigarette Smoker
- Asthma
- Bronchitis
- Emphysema
- Chronic Obstruction
- Sleep Apnea
- Other

**Gastrointestinal**

- Crohn's Disease
- Colitis
- Ulcer
- Acid Reflux
- Celiac Disease
- Other

**Genitourinary**

- Kidney Disease
- Prostate Disease / Cancer
- Benign Prostate Hypertrophy
- Pregnant or Nursing
- Herpes
- Chlamydia
- Other

**Musc/Skel**

- Arthritis
- Osteoarthritis
- Fibromyalgia
- Muscular Distrophy
- Ankylosing Spondylitis
- Osteoporosis
- Gout
- Other

**Integumentary (Skin)**

- Eczema
- Rosacea
- Psoriasis
- Herpes Simplex / Cold Sores
- Herpes Zoster / Shingles
- Other

**Endocrine**

- Type 2 Diabetes
- Type 1 Diabetes
- Thyroid Dysfunction
- Hormonal Dysfunction
- Other

**Hem / Lymph**

- Anemia
- Large Volume Blood Loss
- Ulcer
- High Cholesterol
- Other

**Allergy / Immunology**

- Drug Allergies
- Environmental Allergies
- Rheumatoid Arthritis
- Lupus
- Sjoren's Syndrome
- Other

**None**

- I have no known conditions

Ocular History	Self	Family	Relationship
Condition	✓	✓	
Amblyopia			
Blindness			
Cataract			
Crossed Eyes			
Dry Eye			
Eye Allergies			
Glaucoma / Glaucoma Suspect			
Keratoconus			
Macular Degeneration			
Retinal Detachment			
Eye Injury or Trauma			
Previous Eye or Lid Surgery			
Previous RK, PRK or LASIK			

Family Medical History	✓	Relationship
Condition		
High Blood Pressure		
Cancer		
Diabetes		
Heart Disease		
Thyroid Disease		

Primary Care Physician	
Name	
Phone	
Pharmacy	
Name	
Phone	

Medications		
List all prescription medications, over the counter medications, and supplements.		
Medication Name	Dosage	Reason for the medication

Medication Allergies
List all medications you are allergic to.

Privacy Notice	
<p>Except as outlined in our Privacy Notice version 2013.05.17, our office will not release any of your information to anyone unless specifically authorized by you. You may authorize release of informaton to specific individuals by listing their names below.</p>	
Name	<input type="text"/>
Name	<input type="text"/>
I have received the Privacy Notice and Terms and Conditions Notice.	<input type="checkbox"/> <input checked="" type="checkbox"/>
Initial	<input type="text"/>