Oasis Vision Center, P.C. **Patient Check In Form**

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 section 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	
Salutation	Mr. Mrs. Ms. Dr.
First	
Last	
Middle	
Suffix	(Jr., Sr., II, III, Etc.)
Nickname	
Address	
Address line 1	
Address line 2	
City	
State	
ZIP	
Other Information	
Date of Birth	
SSN Last 4	
Sex	[ ] M [ ] F
Patient Status	[ ] New [ ] Existing
Phone & E-mail	
One phone number is required — Home	
Work	
Cell	
Preferred Phone	[ ] Home [ ] Work [ ] Cell
E-mail	
Preferred method of contact from us	[ ] Home [ ] Work [ ] Cell [ ] E-mail [ ] Text

Person Responsible For Payment If Other Than Patient	
Salutation	Mr. Mrs. Ms. Dr.
First	
Last	
Middle	
Suffix	
Nickname	
Address	
Address line 1	
Address line 2	
City	
State	
ZIP	
Other Information	
Date of Birth	
SSN Last 4	
Sex	[ ] M [ ] F
Oasis Patient	[ ] Yes [ ] No
Phone & E-mail	
One phone number is required — Home	
Work	
Cell	
Preferred Phone	[ ] Home [ ] Work [ ] Cell
E-mail	
Preferred method of contact from us	[ ] Home [ ] Work [ ] Cell [ ] E-mail [ ] Text

Language	
	[ ] English [ ] Spanish
	[ ] Other [ ] Declined to answer
Additional Information	
Marital Status	[ ] Single [ ] Married [ ] Other
Invite requested for	[ ] Trunk Show [ ] Sun Sale
Product Interest	[ ] Glasses [ ] Contact lenses
	[ ] Sunglasses [ ] Other

Employer	
Employer Name	
Position	

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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	[ ] M [ ] F	Sex	[ ] M [ ] F
Phone		Phone	
Phone type	[ ] Home [ ] Work [ ] Cell	Phone type	[ ] Home [ ] Work [ ] Cell
Employer		Employer	

Race		Ethnicity	
	[ ] American Indian or Alaska Native		[ ] Hispanic or Latino
	[ ] Asian		[ ] Not Hispanic or Latino
	[ ] Black or African American		[ ] Declined to answer
	[ ] Native Hawaiian or other Pacific Islander		
	[ ] White		
	[ ] All Other Races		
	[ ] 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 (Currently)
- ☐ 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	✓	✓	
Amblyobia			
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		
Condition	✓	Relationship
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

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.

Name

Name

	✓		
I have received the Privacy Notice and Terms and Conditions Notice.		Initial	