



Eye Care Associates
www.visionсалon.com

Vision Salon Eye Care Associates
Adult & Pediatric Comprehensive Eye Care
PATIENT REGISTRATION INFORMATION

12812 S. Western • Blue Island, IL 60406 • Office: (708) 385-0013 • Fax: (708) 385-1175
840 E. 87th Street – Suite 100 • Chicago, IL 60619 • Office (773) 783-4424 • Fax: (773) 783-3340

Name Dr./Ms./Mr./Mrs. _____ Date _____
 (Circle one) First Initial Last
 Home Phone _____ Work Phone _____ Cell Phone _____ Email _____
 Address _____
 City _____ State _____ Zip Code _____
 Date of Birth _____ Age _____ Employer _____
 Occupation _____ S. S. # _____
 If married, name of spouse _____ Age _____
 Person responsible for account _____
 If child or student please fill in:
 Parent(s) name _____ Occupation _____
 School _____ City _____ Grade _____ Teacher's Name _____

How Were You Referred To Our Office?

Friend/Relative (Please name so we can thank them) _____ Address, if known _____

- Newspaper (Which one?) _____ Radio Yellow Pages Sign Mail Television
 Magazine/Event Ad Other: _____

Do you have vision insurance which may cover part or all of our services? Yes No

If so, check which applies:

- Medicare Blue Cross Blue Shield PPO Private Health Care Systems (PHCS) HFN PPO CCN PPO
 Aetna Wellmark Health Network PPO Vision Service Plan Davis Vision Humana PPO/HMO

Other (Please Name): _____

For all patients, payment is due at the time of service are rendered including co-payment and unmet insurance deductibles.

Method of Payment:

- Cash Check MasterCard/Visa American Express Discover Money Order

So That We Can Better Serve Your Eyes and General Health Needs, Please Fill Out The Following:

Hobbies (Please list): _____

- Do you use a computer more than 30 minutes per day? Yes No
 Does your eyewear have ultraviolet light protection? Yes No
 Do you currently wear prescription eyewear? Yes No

PLEASE TURN OVER AND COMPLETE THE BACK OF THIS FORM ↗

“Without a vision, the people perish...” Proverbs 29:18

Last Examinations	Date	Doctor/Facility	Phone
When was your last physical examination?			
When was your last eye examination?			

Are you currently taking any prescription or over the counter medications? (Please list) _____

Do You Or Any Immediate Family Member Suffer From Any Of The Following?

Who	Who
High Blood Pressure _____	Sinus Trouble _____
Diabetes _____	Glaucoma _____
Arthritis _____	Asthma _____
Heart Disease _____	Hay fever _____
Migraine Headaches _____	Double Vision _____

Do Your Eyes Or Vision Suffer From Any Of The Following?

- | | | | |
|--|----------------------------------|---|---|
| <input type="checkbox"/> Excessive tearing | <input type="checkbox"/> Itching | <input type="checkbox"/> Sensitive to bright lights | <input type="checkbox"/> Blurred distance vision |
| <input type="checkbox"/> Glare | <input type="checkbox"/> Burning | <input type="checkbox"/> Blurred vision at close reading distance | <input type="checkbox"/> Frequent redness in the eyes |

Have you ever had any surgery or injury to the eyes? Yes No If so, when and describe _____

Have you worn or do you presently wear contact lenses? Yes No If so, check below all that applies

Please check type:

- | | | | | | | |
|--------------------------------|----------------------------------|--|--|--|--|-------------------------------------|
| <input type="checkbox"/> Soft | <input type="checkbox"/> Hard | <input type="checkbox"/> Gas Permeable | <input type="checkbox"/> Extended Wear | <input type="checkbox"/> Soft Daily Wear | <input type="checkbox"/> Monthly Replacement | <input type="checkbox"/> Disposable |
| <input type="checkbox"/> Toric | <input type="checkbox"/> Bifocal | <input type="checkbox"/> Colored | <input type="checkbox"/> Keratoconus | | | |

Concerning Payment and Insurance

1. I understand that I (we) are responsible for payment in full to Vision Salon Eye Care Associates at the time services are rendered, unless prior arrangement is made.
2. In the event of default, I (we) understand checks, which are declared non-sufficient funds, will be charges a \$25.00 service fee.
3. Also, in the event of default, I (we) understand and agree to pay a collection fee of 25% of the total owed when sent to collection, all attorney feeds and court costs incurred by the creditor. Once transferred to collection, payment and/or questions are to be directed to the collection agency.
4. By my signature I acknowledge that I have received a copy of Vision Salon Eye Care Associates Privacy Practices.

Patient _____

Date _____

Parent or Responsible Party _____

Relationship to Patient _____