CLARENDON VISION DEVELOPMENT CENTER

Dr. Monika Spokas
Developmental Optometrist
Dr. Amber Cumings, FAAO
Developmental/Pediatric/
Neuro-Optometrist

The information in this history form is critical to the evaluation of your vision. This is your opportunity to tell us about all areas in which your vision is not serving you well.

First Name:_____Last Name:_____Date:_____

What is your main reason for your visit today? _____

_____

Were you referred to our office? Yes ☐ No ☐
If yes, whom may we thank for this referral? _____Phone: _____
Address: _____Email Address: _____
If not referred, how did you learn about our office? _____

HEALTH HISTORY: Circle any conditions that apply to you or that run in your family.

Allergies	☐ Self	☐ Family	Lazy eye	☐ Self	☐ Family
Respiratory disease	☐ Self	☐ Family	Turned eye	☐ Self	☐ Family
Cancer	☐ Self	☐ Family	Color "blind"	☐ Self	☐ Family
Diabetes	☐ Self	☐ Family	Light sensitive	☐ Self	☐ Family
Heart problem	☐ Self	☐ Family	Eyestrain	☐ Self	☐ Family
High blood pressure	☐ Self	☐ Family	Dry eyes	☐ Self	☐ Family
Thyroid	☐ Self	☐ Family	Floaters/spots	☐ Self	☐ Family
Migraines/headaches	☐ Self	☐ Family	Flashing lights	☐ Self	☐ Family
Blindness	☐ Self	☐ Family	Retinal detachment	☐ Self	☐ Family
Head trauma	☐ Self	☐ Family	Macular degeneration	☐ Self	☐ Family
Eye surgery/injury	☐ Self	☐ Family	Cataracts	☐ Self	☐ Family
			Glaucoma	☐ Self	☐ Family

Other medical problems_____

What medications do you currently take? And for what condition?

_____ _____
_____ _____
_____ _____
_____ _____

When was your last eye examination? _____

Do you wear glasses now? ..... ☐ Yes ☐ No
If yes: ☐ for distance only ☐ for near only ☐ full time ☐ when needed ☐ for computer ☐ for sports

Do you wear contact lenses at this time? ..... ☐ Yes ☐ No
If yes: How often? _____ What brand?_____

760 Pasquinelli Drive, Suite 300
Westmont, IL 60559
Tel: 630-323-7300
Fax: 630-323-7662
info@clarendonvision.com
clarendonvision.com

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If no, are you interested in trying contacts? ☐ Yes ☐ No

Do you experience any of the following discomforts at work or at home?

☐ Headaches?
☐ Eyestrain?
☐ Dry eyes?
☐ Difficulty with distance vision?
☐ Near print goes in and out of focus?
☐ Itchy/red eyes?

OCCUPATION: _____

Do you use a computer? ☐ Yes ☐ No Ave. hours/day _____

Do you use a tablet or smart phone? ☐ Yes ☐ No Ave. hours/day _____

RETINAL IMAGING

We are pleased to provide our patients with an advanced digital retinal exam. It is great for documenting a baseline image for our charts, screen for eye diseases, and improve our ability to view your internal retinal health. A dilated exam may still be recommended by the doctor if a more peripheral view of the retina is indicated. Since insurance only covers retinal photos after eye disease is discovered, the Retinal Imaging Exam is an out-of-pocket expense. **The fee is $35.00.**

☐ I want to have my retinal health evaluated with Retinal Imaging.

☐ I do not wish to have Retinal Imaging Exam. I understand that I will still have a thorough eye exam with dilation.

Signature _____ Date _____

PAYMENT POLICY/HIPAA

Examination and procedure fees are due at the time of service and may be submitted to your major medical insurance carrier. Any applicable co-payments are due at the time of service. If you have insurance coverage for these services or materials, we will submit claims for you. However, we are not liable for collecting your claim. After 30 days, we will expect payment in full if your insurance company has not paid. Any balance 90 days after the date of service will incur a monthly billing service charge of $2.00 or 1.3% (15.6% APR) whichever is greater until the balance is paid in full. Returned NSF checks will be charged a service fee of $35.00.

I HEREBY AUTHORIZE MY INSURANCE CARRIER TO MAKE PAYMENT DIRECTLY TO CLARENDON VISION DEVELOPMENT CENTER FOR ANY AND ALL SERVICES RENDERED TO ME BY CLARENDON VISION DEVELOPMENT CENTER. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT COVERED BY INSURANCE.

- I HAVE READ AND AGREE TO THE PAYMENT POLICY STATED ABOVE.

THE OFFICE'S COMPLETE HIPAA POLICY STATEMENT IS AVAILABLE FOR REVIEW UPON REQUEST.

- I ACKNOWLEDGE THAT I HAVE BEEN PROVIDED AN OPPORTUNITY TO REVIEW THE OFFICE'S HIPAA POLICY STATEMENT.

Signature of Responsible Party _____ Date _____

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APPOINTMENT CANCELLATION / NO SHOW POLICY

Thank you for trusting your medical care to Clarendon Vision Development Center. When you schedule an appointment with Clarendon Vision Development Center, we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment, please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment.

- Please provide our office a 24-hour notice if you need to reschedule or cancel your appointment.
- A "No-Show", "No-Call" or missed appointment, without proper 24-hour notification, will be charged a $150 fee. In the event of an emergency where prior notice could not be given, consideration will be given, and a one-time exception may be granted.
- If you are more than 10 minutes late for your appointment, the appointment may be cancelled and rescheduled.
- If a reminder call or message from our office is not received by the patient, the cancellation policy still remains in effect.
- The cancellation/no show fees are the sole responsibility of the patient and must be paid in prior to the patient's next appointment.
- This fee is not billable to your insurance.

If you have any questions regarding this policy, please let our staff know and we will be glad to answer them.

I have read and understand the Appointment Cancellation/No Show Policy and agree to its terms.

Signature of Responsible Party _____ Date _____

Thank you for carefully completing this questionnaire. The information you supplied will allow us to provide a more comprehensive evaluation and better meet your child's specific visual needs.

If you have any questions, please contact our office at (630) 323-7300 prior to your appointment.

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