VISION ASSOCIATES OF WESTLAND
Dr. R.G. Houdek
Dr. C. Jack

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WELCOME TO OUR OFFICE

(please print)
Name _____ (LAST) _____ (FIRST) _____ (MIDDLE INITIAL) Today's Date ___/___/___

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Employer (or School) _____ Occupation (or Grade) _____

Sex M F Social Security # _____ Height _____ Weight _____ Date of Birth ___/___/___

Spouse or Parent Name _____ E-mail Address _____
(circle one)
Marital Status _____ Language _____ Race _____ Ethnicity _____ Preferred Contact Method ☐ Cell ☐ Phone

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Responsible Party Name _____ Driver's License # _____
(person paying for service)
Address if different from above _____

Social Security # _____ Date of Birth ___/___/___

Employer _____

Employer Address _____ Employer Phone _____

Insurance Company _____ Insurance ID # _____ Group # _____

Date of Last Exam ___/___/___ Primary Member Name _____ D.O.B. _____

Who may we thank for referring you to our office _____
Name Address

MEDICAL HISTORY

	(Circle One)
Allergies	No Yes
Asthma	No Yes
Skin Disorder	No Yes
Eye Disease	No Yes
Lazy Eye	No Yes
Cataracts	No Yes
Glaucoma	No Yes
Arthritis	No Yes
Cancer	No Yes
Diabetes	No Yes
Headaches	No Yes
Heart Disease	No Yes
High Blood Pressure	No Yes
Kidney	No Yes
Nerves	No Yes
Other _____	No Yes
Do you use Alcohol	No Yes
Tobacco	No Yes
Recreational Drugs	No Yes
Have you ever smoked?	No Yes

FAMILY MEDICAL HISTORY

	(Circle One)
Blindness	No Yes
Cataracts	No Yes
Glaucoma	No Yes
Diabetes	No Yes
Heart Disease	No Yes
Other _____	No Yes

HOBBIES / ACTIVITIES

☐ Boating	☐ Computer	☐ Golfing
☐ Water Skiing	☐ Hunting	☐ Reading
☐ Scuba Diving	☐ Bowling	☐ Hockey
☐ Softball	☐ Shooting	☐ Fishing
☐ Tennis	☐ Racquetball	☐ Swimming
☐ Snowmobiling	☐ Needlepoint	☐ Snow Skiing

MEDICATIONS (Rx or Over The Counter)

		Name of Medication
Antihistimines	No Yes	_____
Diuretics ("water pills")	No Yes	_____
High Blood Pressure Pills	No Yes	_____
Oral Contraceptives	No Yes	_____
Sleeping Tablets	No Yes	_____
Eye Drops	No Yes	_____
Other _____		

Medication Drug Allergies _____
_____

Do you have any of the following?

Burning ____	Gritty Sensation ____	Spots ____	Double Vision ____
Redness ____	Sensitivity to Light ____	Floaters ____	Headaches ____
Dryness ____	Night Blindness ____	Flashes of Light ____	Dizziness ____

Are you currently wearing contact lenses? No Yes What kind? _____ Solutions _____
Are you interested in contact lenses? No Yes Are you interested in laser vision correction? No Yes

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to Vision Associates of Westland for all insurance benefits otherwise payable to me for services rendered.
I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.
I understand that I am responsible for the balance of any orders that I place, especially a product specially ordered to my prescription or measurements.
I understand that I will be charged a re-billing fee of $5.00 if my balance is not paid within 30 days.
I understand that I may be charged $40.00 if I do not give a 48 hour notice for not showing up for my scheduled appointment.
I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits.
I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____