VISION SOURCE™

DR. JOSEPH DIGIORGIO
DR. STEPHANIE DIGIORGIO

Orland Atrium Building
9031 W. 151St. Street
Orland Park
708 460-2010

Welcome to Our Office

(PLEASE PRINT)

Name _____ Today's Date _____Date of Last Exam _____

Address _____ Date of Birth _____Age _____

City _____ State _____ Zip _____ Sex: M____ F____ Last 4 Digits of Social Security # _____

Home Phone (_____) _____ Spouse's (or Parent's) Name _____

Cell Phone (_____) _____ Medical Insurance _____

E-mail _____ VIsion Insurance _____

Occupation (or Grade) _____

Please Provide Both Your Vision-plan Card & Medical Insurance Card to the Front Desk

How did you first hear about our office?

❒ Referred by a **friend or a relative**

If so, **who may we thank**? _____

❒ Referred by another **doctor or teacher**

If so, who? _____

❒ **Website, ❒ Google, ❒ Yelp, ❒ Facebook,** _____

❒ **Office Sign**

Primary reason for today's visit?

What do you like about your present **Contact Lenses** or **Eyeglasses**?

_____

Any problems with your present **Contact Lenses** or **Eyeglasses**?

_____

Are you planning to **Update your Eyeglasses today?**

_____

DO YOU HAVE ANY OF THE FOLLOWING WITH YOUR EYES?

- Blurry distance vision .....Yes / No
- Blurry near vision .....Yes / No
- Difficulty Working up close .....Yes / No
- Eye strain / tired eyes.....Yes / No
- Light sensitivity.....Yes / No
- Glare or reflections.....Yes / No
- Difficulty Seeing at night.....Yes / No
- Double vision .....Yes / No
- Loss of side vision.....Yes / No
- Flashes / Floaters in vision.....Yes / No
- Sudden vision loss .....Yes / No
- Redness.....Yes / No
- Gritty or sandy feeling .....Yes / No
- Dryness, Burning or Itching .....Yes / No
- Watery or Tearing eyes .....Yes / No
- Mucous discharge.....Yes / No
- Uncomfortable contacts.....Yes / No

Other_____

LIST ALL CURRENT MEDICATIONS (Rx or Over the Counter)

		Name of Medication
High Blood Pressure Meds.....	Yes / No	_____
Diabetes Meds or injections ...	Yes / No	_____
Oral Contraceptives	Yes / No	_____
Eye Drops	Yes / No	_____
Other Medicines.....	Yes / No	_____
Under a physicians care?.....	Yes / No	Name: _____

Please circle any family history for the following eye conditions

		Relationship to patient
Blindness	Yes / No	_____
Cataracts.....	Yes / No	_____
Glaucoma.....	Yes / No	_____
Macular Degen.....	Yes / No	_____
Retinal Detach.....	Yes / No	_____
Lazy Eye.	Yes / No	_____
Other.....	Yes / No	_____

Do you currently wear contact lenses? .....Yes / No

Type: ☐ Soft ☐ Toric ☐ Multifocal ☐ Ortho-K ☐ Rigid gas permeable ☐ Scleral

Brand or design: _____ Current Solution: _____

Interested in contact lenses or specialty-lens options? .....Yes / No

(OVER PLEASE)

Confidential Medical Information. You may discuss this portion directly with the doctor if you prefer

- Do you use Tobacco products .....Yes / No If yes, type / amount / how long: _____
- Do you drink alcohol .....Yes / No If yes, type / amount / how long: _____

Have you ever been exposed to or infected with: ❒ Gonorrhea, ❒ Hepatitis, ❒ HIV, ❒ Syphilis

REVIEW OF MEDICAL SYSTEMS:

- Do you have any allergies to medications?.....Yes / No If yes, please list _____

Please check any conditions you currently have or have previously been diagnosed with:

Vascular / Cardiovascular
☐ Arrhythmia
☐ Cholesterol elevated
☐ High blood pressure
☐ Heart disease

Skin / Integumentary
☐ Skin condition

Endocrine
☐ Diabetes
☐ Thyroid disease
☐ Other endocrine condition

Psychiatric
☐ Anxiety
☐ Depression
☐ Other psychiatric condition

Ears, Nose, Mouth, Throat
☐ Chronic cough
☐ Dry mouth / throat
☐ Sinus congestion

Respiratory
☐ Asthma
☐ COPD / chronic bronchitis

Allergic / Immunologic
☐ Seasonal allergies / Hayfever
☐ Autoimmune disease
☐ Other immune-system disorder

Genitourinary
☐ Genitals/kidneys / bladder

Musculoskeletal / Joints / Muscles
☐ Arthritis or autoimmune disease
☐ Muscle pain

Lymphatic / Hematological
☐ Anemia
☐ Bleeding problems

Constitutional
☐ Fever, Weight loss/gain

☐ **None of the above conditions apply**

Please check activities most important to your vision:

☐ Multiple computer monitors
☐ Phone / tablet use
☐ Night driving
☐ Reading
☐ Outdoor activities /work
☐ Home workshop
☐ Safety eyewear needs
☐ Golf
☐ Tennis / pickleball
☐ Fishing
☐ Biking
☐ Sewing / crafts
☐ Card playing
☐ Music/reading sheet music
☐ Other sports

☐ Other:_____

Please check any visual needs or concerns that apply to you:

☐ Use a computer or digital device for extended periods
☐ Are bothered by head tilting or restricted areas of clear vision
☐ Have problems with glare or night driving
☐ Do not currently have polarized prescription sunglasses
☐ Are interested in thinner, lighter lenses
☐ Are interested in newer contact lens technology
☐ Would prefer clear daytime vision without glasses or contact lenses
☐ Have a child whose nearsighted prescription continues to increase

Payment Policy, Insurance Billing, and Privacy Acknowledgment

Vision Plan and Medical Insurance Billing
Vision plans generally apply to routine eye examinations performed primarily to determine an eyeglass or contact-lens prescription. Medical insurance may be billed when the doctor evaluates or manages symptoms, reduced vision, or a medical eye condition.

Examples may include diabetes when an eye-health evaluation or physician report is required, cataracts, glaucoma, prior cataract surgery, eye infections, flashes or floaters, eye pain, sudden or unexplained vision changes, and other conditions that may affect the health of the eyes. The insurance billed is based on the reason for the visit, the doctor's examination findings, and the services provided that day.

Refraction Acknowledgment
Refraction determines the best-corrected vision, helping the doctor assess whether reduced vision may be due to a medical condition. Medical plans, like Medicare, BCBS, etc., do not cover refraction. Our refraction fee is **$48**. Vision-plan benefits may sometimes be coordinated with medical insurance, depending on the patient's plan.

_____ **Patient/Guardian initials confirming review of the insurance billing and refraction information above.**

Payment is required at the time of service
Insurance benefit information is an estimate and is not a guarantee of payment. The patient is responsible for applicable copays, deductibles, coinsurance, noncovered services, and balances remaining after insurance processing.

How will you settle your account today?

☐ Check ☐ Cash ☐ Credit

I authorize payment of insurance benefits to this office and authorize the release of information necessary to process claims. I acknowledge that I have reviewed this office's **Notice of Privacy Practices** and accept financial responsibility for charges not paid by insurance.

Thank You

Patient/Guardian Signature: _____ **Date:** _____