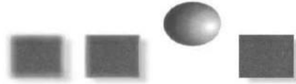


(702) 733-2020

PATIENT INFORMATION
(Información del Paciente)

PATIENT NAME (LAST) ***(APELLIDO NOMBRE)***	**(FIRST)** ***(PRIMER)***	**(M.I)**	**SSN** ***(SEGURO SOCIAL):***

HOME PHONE ***(NÚMBERO DE TELÉFONO)***	CELL PHONE *(CELULAR)*	SEX *(SEXO)*	**DATE OF BIRTH** ***(FECHA DE NACIENTO)***	AGE *(EDAD)*

MARITAL STATUS *(ESTADO MATRIMONIAL)*
□**SINGLE** *(SOLTERO)*□ MARRIED *(CASADO)* □**DIVORCED** *(DIVORCIADO)* □**WIDOWED** *(VIUDO)* □**SEPARATED** *(SEPARADO)*

ADDRESS ***(DOMICILIO)*** **(Include: APT#/ STE#/ TRAILER SPACE)**		**E-MAIL ADDRESS:**
CITY ***(CIUDAD)***	**STATE** ***(ESTADO)***	**ZIP** ***(CODIGO POSTAL)***

PATIENT'S EMPLOYER *(POSICION DE TRABAJO* See below if patient is a minor or unemployed) *(Vea abajo si paciente es un menor)*	OCCUPATION *(TRABAJO)*

EMPLOYER'S ADDRESS *(DOMCILIO DEL TRABAJO)*		WORK PHONE *(TELEFONO DEL TRABAJO)*
CITY *(CIUDAD)*	STATE *(ESTADO)*	ZIP *(CÓDIGO POSTAL)*

WHO TO NOTIFY IN CASE OF EMERGENCY (Not living with you) *(QUIEN NOTIFICAR EN CASO DE EMERGENCIA (No viviendo con usted))*	PHONE *(TELÉFONO)*	RELATIONSHIP (RELACIÓN AL PACIENTE)

ADDRESS *(DOMICILIO)*	CITY *(CIUDAD)*	STATE *(ESTADO)*	ZIP *(CODIGO POSTAL)*

LOCAL PHARMACY NAME (Farmacia de su localidad)	PHONE (Telefono)	ADDRESS/CROSS STREETS (dirección/interseccion de calles)
PHARMACY MAIL ORDER SERVICE (Farmacia envios por correo)	PHONE (Telefono)	ADDRESS (dirección)

SPOUSE OR PARENT INFORMATION
(Esposa/Esposo o información de tus padres)

NAME (LAST) ***(APELLIDO NOMBRE)***	**(FIRST)** ***(PRIMER)***	**(M.I)**

HOME PHONE ***(NUMBERO DE TELEFONO)***	CELL PHONE *(CELULAR)*	**D.O.B.** ***(FECHA DE NACIMIENTO)***	**SSN:** ***(SEGURO SOCIAL)***

ADDRESS ***(DOMICILIO)***	**CITY** ***(CIUDAD)***	**STATE** ***(ESTADO)***	**ZIP (CODIGO POSTAL)**

EMPLOYER *(POSITION DE TRABAJO)*	OCCUPATION *(TRABAJO)*	WORK PHONE: *(TELEFONO DEL TRABAJO)*

EMPLOYER ADDRESS *(DOMCILIO D DEL TRABAJO)*	CITY *(IUDAD)*	STATE *(ESTADO)*	ZIP (ODIGO *POSTAL)*

INSURANCE INFORMATION
(Información ***de Seguro Medico)***

NAME OF PRIMARY INSURANCE (NOMBRE DEL SEGURO PRIMARIO)	**NAME OF SECONDARY INSURANCE (NOMBRE DEL SEGURO SECUNDARIO)**
NAME OF INSURED OF PRIMARY INSURANCE (NOMBRE DEL ASEGURADO)	**NAME OF INSURED OF SECONDARY INSURANCE (NOMBRE DEL ASEGURADO)**
DATE OF BIRITH OF INSURED (FECHA DE NACIMIENTO DEL ASEGURADO)	**DATE OF BIRITH OF INSURED (FECHA DE NACIMIENTO DEL ASEGURADO)**
SSN OF INSURED OF PRIMARY INSURANCE (SSN DEL ASEGURADO)	**SSN OF INSURED OF SECONDARY INSURACE (SSN DEL ASEGURADO)**

The above information is complete and correct. *(La información probehida esta completa y correcta.)*

X____ ____________________X___________________________________
PATIENT SIGNATURE *(FIRMA DEL PACIENTE)* DATE *(FECHA)*GUARANTOR SIGNATURE (FIRMA *de GARANTE)*

WELLISH VISION INSTITUTE

(702) 733-2020

KENT L. WELLISH, M.D.
JAY K. MATTHEIS, M.D.
MAZEYAR SABOORI, M.D.
KENNETH C. MCCANDLESS, O.D.
ALEXANDER CHOY, O.D.
ISAAC ORTIZ, O.D.

YOUR NAME: ____ TODAY'S DATE: _____________________

WHO IS YOUR OPTOMETRIST? ______________________________ ADDRESS: __________________________
OPTOMETRIST PHONE: ____

WHO IS YOUR FAMILY DOCTOR? ____________________________ ADDRESS: ___________________________
FAMILY DOCTOR PHONE: ____

WHO REFERRED YOU TO OUR CLINIC? ____
WHEN WAS YOUR LAST MEDICAL EXAM? ____

WHY ARE YOU BEING SEEN TODAY? (DESCRIBE YOUR EYE PROBLEM):
____

PLEASE CIRCLE YES OR NO ON ALL OF THE FOLLOWING MEDICAL PROBLEMS

STROKE	YES	NO	HEART ATTACK	YES	NO
HEADACHES	YES	NO	RHYTHM PROBLEM	YES	NO
WEAKNESS	YES	NO	HEART FAILURE	YES	NO
DEPRESSION	YES	NO	HIGH BLOOD PRESSURE	YES	NO
HEARING LOSS	YES	NO	HEART MURMUR	YES	NO
SHORTNESS OF BREATH	YES	NO	HIGH CHOLESTEROL	YES	NO
ASTHMA	YES	NO	DIABETES	YES	NO
EMPHYSEMA/COPD	YES	NO	THYROID PROBLEMS	YES	NO
ALLERGIES/HAY FEVER	YES	NO	CANCER	YES	NO
HIV/AIDS	YES	NO	ARTHRITIS	YES	NO
HEPATITIS	YES	NO	BLEEDING DISORDER	YES	NO
SHINGLES	YES	NO			
HERPES/COLD SORES	YES	NO	CHRONIC DIARRHEA	YES	NO
			CHRONIC CONSTIPATION	YES	NO
KIDNEY PROBLEMS	YES	NO	ULCERS	YES	NO
BLADDER PROBLEMS	YES	NO	SKIN RASHES	YES	NO
LIVER DISEASE	YES	NO	WEIGHT LOSS	YES	NO

PLEASE LIST ANY PAST SURGERIES

____________________________ ____________________________ __________________________

Have you stayed overnight in the hospital in the last three months? YES NO
Have you had problems with anesthesia in the past? YES NO
Can you lie flat of your back for one hour without significant discomfort or breathing problems? YES NO

PLEASE CIRCLE ANY OF THE FOLLOWING EYE CONDITIONS YOU HAVE EXPERIENCED

RETINAL DETACHMENT	YES	NO	RETINAL SURGERY	YES	NO
GLAUCOMA	YES	NO	DRY EYE	YES	NO
GLAUCOMA SURGERY	YES	NO	EYE INJURIES	YES	NO
CATARACTS	YES	NO	STIES/CHALAZIONS	YES	NO
MACULAR DEGENERATION	YES	NO	CATARACT SURGERY	YES	NO
REFRACTIVE SURGERY	YES	NO	LAZY EYE	YES	NO
LASER SURGERY	YES	NO	CROSSED EYES	YES	NO

DO YOU HAVE ANY OF THE FOLLOWING EYE SYMPTOMS

BURNING	YES	NO	REDNESS	YES	NO
SANDY/GRITTY	YES	NO	ITCHING	YES	NO
MUCOUS DISCHARGE	YES	NO	CONTACT LENS DISCHARGE	YES	NO
TIRED EYES	YES	NO			

GENERAL EYE QUESTIONS

DO YOU USE ARTIFICIAL TEARS YES NO
WHAT BRAND? ______________________________

DO YOU WEAR CONTACT LENSES? YES NO
HOW LONG? _________________________________

DO YOU WEAR GLASSES? YES NO
HOW LONG? ________________________________

HAVE YOU TRIED CONTACTS BEFORE? YES NO

HAVE ANY FAMILY MEMBERS EVER HAD?

CATARACTS	YES	NO	BLINDNESS	YES	NO
RETINAL DISORDERS	YES	NO	GLAUCOMA	YES	NO
LAZY EYE	YES	NO	STRABISMUS	YES	NO

DO YOU NOW OR HAVE YOU EVER USED

ALCOHOL	YES	NO	FREQUENCY____
TOBACCO	YES	NO	FREQUENCY____
DRUGS	YES	NO	FREQUENCY____

LIVING SITUATION

DO YOU RESIDE IN:	HOME	APARTMENT	WITH FAMILY	FRIENDS	ALONE
ARE YOU:	MARRIED	SINGLE	DIVORCED		

CURRENT MEDICATIONS	DOSAGE	EVER HAD ALLERGIC REACTION TO ANY MEDICINE(S)? If So, List
____________________________	__________	______________________________
____________________________	__________	______________________________
____________________________	__________	______________________________
____________________________	__________	______________________________
____________________________	__________	______________________________
____________________________	__________	______________________________
____________________________	__________	______________________________
____________________________	__________	______________________________
____________________________	__________	

*Do you use aspirin, plavix, coumadin or other blood thinner? YES NO
*Have you ever had an allergic reaction to latex? YES NO

____________________________________ PATIENT SIGNATURE

____________________ DATE

Release of Information

Please list anyone that you would like us to share your Protected Health Information with.

Name: ______________________________ Relationship to Patient: ____________________________

Name: ______________________________ Relationship to Patient: ____________________________

PATIENT HEALTH INFORMATION CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you and/or your representative consent to our use and disclose of protected health information about you for treatment, payment, health care, and other HIPAA allowed operations. You have the right to revoke this Consent, in writing, signed by you. However, such revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies. Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon the execution of this Consent.

Patient Name_______________________________________
Patient Signature____________________________________

Patients who wish to select a person(s) to represent them in care must provide the name and original signature of their designated representative(s) to Wellish Vision Institute. Access to patient information will be available to those persons whose signatures are on this form.

Patient Requested Representative Name_______________________________
Relationship to Patient____________________________
Representative Signature__________________________
Date: ________________

In front of _____________________________________
Printed name-Practice representative

v. 1/10/2019

Glasses Policy at Wellish Vision Institute

At Wellish Vision, we are proud to provide our patients with the very best in Medical and Surgical Eye Care.

We realize, however, that we are not experts at glasses or contact lenses. For this reason, although we may perform a refraction for medical purposes, we like to make clear to our patients that we do not prescribe glasses or contact lenses.

There are many expert Doctors of Optometry who do a terrific job at prescribing glasses.

We will be happy to provide you with a referral to one or several experts for glasses or contact lenses in your area, upon your request or after your surgery if you have surgery with one of our doctors.

This policy allows us to focus on what we are the best at, while offering you great alternatives for glasses and contact lens services that others are better suited to provide for you.

If you feel you understand and agree with our policy, **please sign below.**

If you cannot agree to this policy, we will be happy to refer you to the Clark County Medical Society for an alternative Eye Care professional who might serve your needs. Their contact number is (702) 739-9989 and their website is info@clarkcountymedical.org.

Thank you!

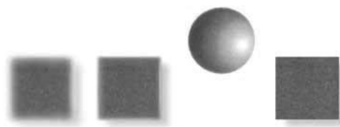
I understand and accept that my eye care at Wellish Vision does not include receiving a prescription but that if I need glasses, the doctors and staff will provide me with a referral for exam and glasses by a qualified Eye Care Provider.

Patient Name: ____

Signature: ____

Today's Date: _________/__________/___________

v. 1/10/2019



WELLISH VISION INSTITUTE
LASER & SURGERY CENTER

LIFETIME INSURANCE AUTHORIZATION

I authorize the release of any medical or other information necessary to process insurance claims for myself or for my dependent named below and further, request, authorize and direct payment of government benefits under XVIII of the social security act or other benefits payable under my insurance plan(s) directly to the named provider. Wellish Vision Institute for myself or my dependent named below. I agree to pay the balance of expenses not paid under my insurance plans. I also understand that this authorization will be maintained with my medical records. I hereby make, Wellish Vision Institute my authorized representative to act on my behalf to obtain insurance payments and to serve as my representative in obtaining contract benefits from my Insurance provider.

DATE: ________ ____

Policyholder or responsible party signature

____

PRINT - Policyholder or responsible party name

COLLECTION POLICY

I, (Patient Name) ____ hereby, agree to be financially responsible for all charges incurred regardless of insurance coverage. In the event my account is referred to a collection service due to lack of payment on my part, I agree to pay all collection/legal fees that may be added to my account, including, but not limited to a finance charge of 1.5% a month (18% APR). If my account is over paid and a credit is smaller than $2.00, a refund check will not be issued, due to handling expense.

Returned checks: A $25.00 NSF fee will be charged for checks initially returned unpaid by your bank. If the same check is returned unpaid a second time, it may be referred to a collection service for recovery.

____ ____________________________

Signature Patient or Responsible Party Date

PATIENT AUTHORIZATION OF INFORMATION

Patients who wish to select a person(s) to represent them in care must provide the name and original signature of their designated representative(s) to Wellish Vision Institute.
Access to patient information will be available to those persons whose names are on this form!

Patient Representative: _________________________ Relationship to Patient: _______________________

Representatives Signature: ___________________________ Date: ______/______/_______

Witness: ____

v. 1/10/2019