



Vision Wellness Center

Dr. Lilien Vogl and Dr. Adam J. Lee
Optometrists

Our Mission

It is our goal to provide our patients with the highest quality eye care and service. We are devoted to our community in and out of the office. Our knowledgeable staff and doctors are committed to excellence in meeting each patient's unique visual and eye health needs with the highest ethics and integrity.

WELCOME TO OUR OFFICE

(PLEASE PRINT AND FILL OUT COMPLETELY)

Name _____

Today's Date _____

Date of Birth _____

Social Security Number _____

Address _____

Phone Number _____

Phone Number _____

Email Address _____

Spouse or Parent _____

Referred By: _____

Employer (or School) _____

Occupation (or Grade) _____

What is the major purpose of this visit? _____

Any problems with your present contact lenses or glasses? _____

Please sign below on arrival to our office. You will receive a copy of the Notice of Privacy Practices at that time.

I acknowledge that I received a copy of Drs. Vogl and Lee Notice of Privacy Practices

Signature _____ Date _____

VISUAL NEEDS

Do You..... (check the box if your answer is yes)

- Work at a computer?
- Have only one pair of glasses?
- Want information on thinner, lighter lenses?
- Wear bifocals?
- Want information on lineless bifocals?
- Prefer not to wear your glasses at times?
- Interested in information on LASIK vision correction surgery?
- Interested in a non-surgical approach to vision correction?
- Have problems with glare or reflections (even night driving)?
- Do work requiring safety glasses?
- Participate in sport activities? What? _____
- Interested in a 'test drive' in the latest contact lens technology?
- Hobbies? What kind? _____

Do you experience..... (check those that apply)

- | | |
|--|---|
| <input type="checkbox"/> Burning | <input type="checkbox"/> Uncomfortable glasses |
| <input type="checkbox"/> Itchiness | <input type="checkbox"/> Sudden loss of vision |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Sensitivity to Sunlight |
| <input type="checkbox"/> Watery Eyes | <input type="checkbox"/> Fainting or dizziness |
| <input type="checkbox"/> Double Vision | <input type="checkbox"/> Blurry distance vision |
| <input type="checkbox"/> Flashes of Light | <input type="checkbox"/> Blurry near vision |
| <input type="checkbox"/> Glare or Reflection | <input type="checkbox"/> Gritty feeling in eyes |
| <input type="checkbox"/> Soreness | <input type="checkbox"/> Objects floating in vision |
| <input type="checkbox"/> Eye Strain | <input type="checkbox"/> Trouble seeing at night |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Occasional Dryness |
| <input type="checkbox"/> Redness | <input type="checkbox"/> Other |

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PATIENT INSURANCE INFORMATION

Patient's Name _____ Provider's Name: Lilien Vogl O.D.
Adam J Lee O.D.

I request that payment under my insurance program be made to the provider named above on any bills for services furnished to me during the effective period of this authorization and I authorize the above named provider to release to the Insurance Company, or its intermediaries or carriers any information needed for this claim or any related claim. I further permit a copy of this authorization to be used in place of the original.

VISION PLAN:

Insurance Provider _____ (example: VSP, EyeMed, Avesis)
Primary's Name _____ Primary's DOB ____/____/____
Primary's SSN ____-____-____ Primary's ID # _____
Relationship to Insured _____

MEDICAL INSURANCE:

Insurance Provider _____ (example: BCBS, Cigna, Aetna)
Primary's Name _____ Primary's DOB ____/____/____
Primary's SSN ____-____-____ Primary's ID # _____
Relationship to Insured _____

SECONDARY MEDICAL INSURANCE:

Insurance Provider _____ (example: BCBS, Cigna, Aetna)
Primary's Name _____ Primary's DOB ____/____/____
Primary's SSN ____-____-____ Primary's ID # _____
Relationship to Insured _____

I authorize payment of medical benefits to the optometrist or supplier for services rendered.

The Insurance Company will only pay for services that it determines to be "reasonable and necessary". If the Insurance company determines that a particular service, although it would otherwise be covered, is "not reasonable and necessary"; they will deny payment for that service. If the Insurance Company denies payment, I agree to be personally and fully responsible for payment.

Signature _____ Date _____