# Scott L. Nehring, O.D., P.C.
# Welcome Back To Our Office

**Welcome to Woodburn Vision Source. Thank you for choosing us for your eyecare needs. We are delighted to have you as a patient and appreciate the confidence you placed in us. Please take a moment to complete the following information. Any information we already have on file will appear on this form. Please review all completed areas to ensure that the information we have is current and accurate. If you have any questions, please do not hesitate to ask.**

☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms. ☐ Male ☐ Female

First Name _____ MI _____ Last Name _____ Preferred Name _____

Street Address _____ City _____ State _____ Zip _____

Social Security Number _____ Date of Birth _____ ***Cell Phone*** _____ Home Phone _____

***E-mail Address*** _____ Person Responsible for Account _____

***Emergency Contact Person*** _____ ***Emergency Contact Phone #*** _____

**Patient Status**
☐ Single ☐ Married ☐ Other

***Race***

☐ American Indian Or Alaska Native
☐ Asian
☐ Black Or African American
☐ Native Hawaiian Or Other Pacific Islander
☐ Other Race _____
☐ White
☐ Native American
☐ Caucasian
☐ Refuse To Specify
☐ Not Disclosed

| | ft | in | cm/m | |
|---|---|---|---|---|
| ***Height*** | | | | ◉ ft in ○ cm |
| ***Weight*** | | | | ◉ lbs ○ kg |

***Ethnicity*** _____ ***Preferred Language*** _____

***Smoking Status:*** _____

**PRIMARY INSURANCE INFORMATION**

Primary Insurance Company _____ Insured's Id # _____ Group Number _____

Insured's First Name _____ MI _____ Insured's Last Name _____ Insured's DOB _____

**SECONDARY INSURANCE**

Secondary Insurance Company _____

**NAME OF PRIMARY CARE PHYSICIAN** _____

**CLINIC NAME FOR PCP** _____

**NAME OF REFERRING PHYSICIAN** _____

**CLINIC NAME FOR REFERRING PHYSICIAN** _____

**Please Read:**

In order to control the cost of billing, we ask that the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. We would rather control billing costs than be forced to raise our fees. All professional services and material are charged to the patient.The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks.

Payment from my insurance is to be paid directly to Woodburn Vision Source. I understand that will be billed as my primary insurance. I understand that billing any secondary insurance is my responsibility. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed.

Signature _____ Date _____

# PATIENT HISTORY AND INFORMATION

Name:

## HEALTH HISTORY

What is the main reason for today's exam ? _____

Current Occupation : _____ Employer _____

Past Eye Surgeries: _____

Current Medications: _____

_____

Current Eye Drops: _____

Medicines that cause reactions or sensitivities: _____

## EYE HISTORY

| | | | | | |
|---|---|---|---|---|---|
| Blurred Vision | ○ Yes ○ No | Dryness/Burning | ○ Yes ○ No | Infection of Eyes or Lids | ○ Yes ○ No |
| Computer Strain/Tired Eyes | ○ Yes ○ No | Redness | ○ Yes ○ No | Eye Pain | ○ Yes ○ No |
| Glare/Light Sensitivity | ○ Yes ○ No | Headaches | ○ Yes ○ No | | |

## GENERAL HEALTH CONDITION

| | | | | | |
|---|---|---|---|---|---|
| Fever | ○ Yes ○ No | Respiratory (Asthma) | ○ Yes ○ No | Anxiety or Depression | ○ Yes ○ No |
| Diabetes | ○ Yes ○ No | Gastrointestinal | ○ Yes ○ No | Thyroid | ○ Yes ○ No |
| Ears,Nose,Throat | ○ Yes ○ No | Kidney | ○ Yes ○ No | Blood/Lymph | ○ Yes ○ No |
| Cardiovascular/Hypertension | ○ Yes ○ No | Muscles, Bones, Joints | ○ Yes ○ No | Allergies | ○ Yes ○ No |
| Cholesterol | ○ Yes ○ No | Skin | ○ Yes ○ No | Are you? | ☐ Pregnant |
| | | Neurological | ○ Yes ○ No | | ☐ Nursing |

## FAMILY HISTORY

| | | | | | |
|---|---|---|---|---|---|
| Cataract(s) | ○ Yes ○ No | Diabetes | ○ Yes ○ No | Heart Disease | ○ Yes ○ No |
| Glaucoma | ○ Yes ○ No | Macular Degeneration | ○ Yes ○ No | High Blood Pressure | ○ Yes ○ No |