INSURANCE INFORMATION

Vision Insurance: (skip to next section if there is no vision insurance)

Insurance Name _____

Policy Holder's Name(Main Member) _____

Policy Holder's date of birth: _____

Insurance ID Number (usually member's social)_____

Medical Insurance/Policy Holder's Info: (skip to next section if there is no medical insurance)

Insurance Name _____ ID # _____

Policy Holder's Name(Main Member) _____

Policy Holder's date of birth:_____Relationship to Patient _____

Responsible Party: I authorize the eye doctors at the Optical Center to furnish information to insurance carriers, referring physicians or legal guardians (for minors) concerning my eye conditions and treatments, or information needed for this or related claims, I also assign to these doctors all payments for medical services rendered at his offices understand that I am responsible for any amount not covered by insurance. Any payments due from my insurance company but not paid is my responsibility and I will be responsible for this amount.

Person Responsible for Payment _____ Relationship _____

Signature _____ Date: _____

Privacy Statement: the Federal government has passed a law dealing with the privacy of your records (HIPAA). This Act describes how your medical information may b e used and disclosed. The following is a brief overview of our office policy. A very detailed notice will be posted in our office and you may request a copy.

- We will use your health care information to treat you.
- We may disclose your information to other health care providers for the purpose of treatment.
- We will use your information to bill your insurance company for payment.
- We may call or write to remind you of appointments or eyewear ready for pickup. We may leave a message on your answering machine.
- We will not make any other uses of disclosures of your information unless you sign a written authorization.

Signature _____ Date _____

Please list who may call on behalf of yourself. This person(s) will be able to receive any and all personal medical information:

_____ _____

Name Relationship

_____ _____

Name Relationship

WELCOME TO OUR OFFICE!

PATIENT INFORMATION: Please print.

Name_____ Date____/____/_____
Mailing Address_____
City_____ State_____ Zip_____
Phone: Home_____ Cell_____
Email: _____
(Please provide an email and cell number for appointment reminders and coupons, internal use only.)
Date of Birth_____ Occupation _____
If under 18, Parent/Guardian's name_____
Date of last exam _____ Place _____

Do you currently wear glasses? Yes No
Do you currently wear contacts? Yes No If not, are you interested in contacts? Yes No

Reason for visit _____
Soc. Security _____ Gender M F Marital Status S M D W

Medical History:

Medical Doctor_____ Last Visit _____
Address _____ Phone _____
Any recent medical problems? _____

Circle any conditions that applies to patient:

Heart disease	Diabetes	**List Medications:**
Arthritis	Asthma/Allergies	_____
Lazy eye (Amblyopia)	Pregnant	_____
Thyroid	High Blood Pressure	_____
Headaches		

List any allergies to medications: _____

Eye Health History:

Any injuries or surgeries to your eye? Yes No **If yes, explain**

_____

Is there a family history of: Glaucoma Cataracts Retinal Disease Diabetes Macular Degeneration

Circle that applies to patient: (With current eyewear, if any)

Blurred vision	Tearing	Dry eye
Double vision	Eyelid Problems	Eye Pain
Tired when reading	Glaucoma	Irritation
Spots/Floaters	Cataracts	Redness
Flashes	Sudden vision loss	Itching

CONTINUE TO BACK