PATIENT INFORMATION

PLEASE COMPLETE ALL QUESTIONS, CHECK AND SIGN

Name ____________________________ What do you prefer we call you (Nickname)___________________ Home Phone _____________________

Address____City______________Zip______________Cell Phone________________________

SS#_____________________ Date of Birth_______________ Age______ Race/Ethnic Group_______ Sex______ Martial Status_______________

Patient's School/Employer________________________________Grade/Occupation____________________Work Phone_____________________

When and Where was
Your last eye exam?__________________________ How did you hear of us?_________________ E-mail address___________________________

Parent or Spouse's Name_______________________ Dependents Names and Ages____
(Circle any who are Patients)

Name of Relative
Not living with you______________________________Phone______________________Address____

Do you use __Glasses __Contacts? Do you want new __Contacts __Glasses for;__Regular use__Reading__Sun__Sports__Computer use__Work

What can we do for you today?
Do you have a Specific Problem or Need?____

Eye History, Including any Disease, Injuries, Surgery, Vision Training____

General Medical Problems or Condition: (Check any that apply)

__General/Constitutional __Ear, Nose or Throat __Allergic/Immunologic __Respiratory __Skin __Gastronintestianal
__Cardiovascular Disease __Muscle, Bones or Joints __Genital, Kidney or Bladder __Blood/Lymph __Neurological __Psychiartic/Emotional

Specify any Medical Conditions you have or had____
(such as Hypertension, Diabetes, Cancer, Arthritis, HIV
TB, Depression, Thyroid, Stroke, Head or Neck Trauma)____

Current Medications____

Allergies including Medication you are Allergic to____ Name of your Physician__________________

Family History of Eye Disease or Blindness?____

Hobbies and Interests__________________________________ Do you Smoke?________________ Do you Drink Alcohol?___________________

Who is Responsible for this Account________________________________ Relationship to patient___________________ Phone______________

Please indicate how your part of payment will be made. __ Cash__ Check__ Credit Card __I wish to discuss another type of billing arrangement

IF YOU WISH US TO BILL AN INSURANCE COMPANY FOR YOU, THE FOLLOWING INFORMATION IS REQUIRED.

Failure to Supply the information required to bill, will result in payment in full at the time of service.

Insurance Company	________________	________________	________________
Subscriber Name	________________	________________	________________
Subscriber's DOB	________________	________________	________________
Subscriber's SSN	________________	________________	________________
Relationship to Patient	________________	________________	________________
Policy Number	________________	________________	________________
Employer	________________	________________	________________

PROCEDURES MAY BE INDICATED AND DISCUSSED THAT EXCEED THE MINIMUM THAT IS APPROVED BY INSURANCE

(IF INSURED __ **I DO** authorize those services today. I want complete and optimal eye care even if I incur out of pocket costs.
Check One) __ **I DO NOT** authorize those services today, I don't want extra out of pocket costs so limit my care to what should be covered.

I authorize and consent to the examination and treatment of the above patient. I certify that the above information is correct. I authorize the doctor to release any information needed to process my insurance claims and I assign payment to the provider of any benefits. I am responsible for any fees incurred and any additional cost of collection including reasonable attorney's fees and interest at 2% per month on any unpaid balance on this account and I agree to promptly pay amounts due when incurred or upon insurance denial.

PLEASE SIGN HERE ____ **DATE**_____________________

PATIENT'S SIGNATURE (IF A MINOR THE PARENT OR GUARDIAN MUST SIGN)

**Patient records only maintained for six (6) years after last encounter (visit).