A Center for VisionCare
PATIENT INFORMATION
(Please Print)

Today's date:_____ **REFERRED BY**:_____

PATIENT INFORMATION

Mr. Mrs. Ms. _____ Social Security #: _____

Address: _____ City: _____ ST:____ ZIP:_____

Is this a Nursing Home or Assisted Living Facility? ❑ Yes ❑ No Home Phone: _____

Date of Birth: _____ Age:_____ Sex: ❑ M ❑ F Race: _____ Cell Phone: _____

E-Mail Address: _____

Marital Status: Single / Married / Divorced / Separated / Widowed Name of Spouse: _____

Patient Employed By: _____ Patient Occupation: _____

Employer Address: _____ Work Phone: _____

PRIMARY CARE PHYSICIAN INFORMATION

Medical Doctor: _____ Phone: _____

Medical Doctor's Address:_____ City: _____ ST:____ ZIP:_____

PHARMACY INFORMATION

Your Pharmacy: _____ Phone: _____

Pharmacy Address_____ Fax: _____

IN CASE OF EMERGENCY

Name (not living at same address): _____ Relationship to patient: _____

Home Telephone: _____ Work Telephone: _____

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

PRIMARY Insurance company name: _____ ID# _____

Mailing Address: _____ Group# _____

Name of Insured: _____ Relationship to Patient: _____

Date of Birth of Insured: _____

SECONDARY Insurance company name: _____ ID# _____

Mailing Address: _____ Group# _____

Is Medicare your primary insurance: Yes ❒ No ❒ Medicare # _____

Payment information for first visit: Check ❒ Cash ❒ Credit Card ❒ Insurance ❒

CURRENT EYE HEALTH CONDITIONS / HISTORY

(Check any of the following if you currently have, or have had in the past.)

		How Long?			How Long?
❑	Blurred Vision	_____	❑	Headaches	_____
❑	Cataracts	_____	❑	Loss of Vision	_____
❑	Crossed Eyes	_____	❑	Retinal Disease	_____
❑	Double Vision	_____	❑	Seeing Flashes	_____
❑	Eye Infection	_____	❑	Seeing Halos	_____
❑	Eye Injury	_____	❑	Sensitivity to Light	_____
❑	Eye Surgery	_____	❑	Wear Contact Lenses	_____
❑	Floaters	_____		Type of Lens:	_____
❑	Glaucoma	_____		Hours per Day:	_____

MEDICATIONS

Please list all

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

ALLERGIES

Please list all

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

HEALTH HISTORY

Please check the appropriate line "yes" or "no" to indicate if you have had any of the following. Also place a mark to indicate if a blood relative has had any of the following problems.

	Yourself		Family Member			Yourself		Family Member	
AIDS/HIV	___Yes	___No	___Yes	___No	Hepatitis (Type _____)	___Yes	___No	___Yes	___No
Arthritis	___Yes	___No	___Yes	___No	High Blood Pressure	___Yes	___No	___Yes	___No
Artificial Heart Valve	___Yes	___No	___Yes	___No	Kidney Disease	___Yes	___No	___Yes	___No
Artificial Joints	___Yes	___No	___Yes	___No	Lupus	___Yes	___No	___Yes	___No
Asthma	___Yes	___No	___Yes	___No	Migraine Headaches	___Yes	___No	___Yes	___No
Bleeding	___Yes	___No	___Yes	___No	Pacemaker	___Yes	___No	___Yes	___No
Cancer	___Yes	___No	___Yes	___No	Rheumatic Fever	___Yes	___No	___Yes	___No
Chemical Dependency	___Yes	___No	___Yes	___No	Shingles	___Yes	___No	___Yes	___No
Diabetes	___Yes	___No	___Yes	___No	Skin Conditions	___Yes	___No	___Yes	___No
Drug Sensitivity	___Yes	___No	___Yes	___No	Stroke	___Yes	___No	___Yes	___No
Emphysema	___Yes	___No	___Yes	___No	Thyroid Conditions	___Yes	___No	___Yes	___No
Hay Fever	___Yes	___No	___Yes	___No	Are you pregnant?_____			# of Children_____	
Heart Condition	___Yes	___No	___Yes	___No	Tobacco Use _____			Alcohol Use _____	

FINANCIAL ASSIGNMENT AND AGREEMENT

Cash Patients:
If you do not have a valid insurance plan to cover the costs of our services you will need to make full payment at the time of service. We accept cash, checks, or credit cards. Other payment arrangements may be arranged with the practice administrator prior to treatment.

Medicare Patients:
Please remember that your deductible must be met for each calendar year.

Private Insurance/Third Party Injury Patients:
We will bill your insurance as a courtesy to you. (Note: Your insurance policy is a contract between you and the insurance company. We are not a party to that contract. Therefore, you are completely responsible for the cost of your unpaid treatment.)

HMO/PPO Patients:
You are responsible for your contracted portion of reimbursement or co-payment at the time of service. If your co-payment is not made at the time of service, an additional fee may be charged for administrative costs.

Missed Appointments:
Due to our efforts to accommodate all patients when they need to be seen, we ask that if you are unable to keep your scheduled appointment, that you cancel no later than 24 hours in advance. We understand that although circumstances at times may prevent doing this, after a second missed appointment we may add a $25.00 missed appointment charge to your account.

Minor Patients:
Written or verbal parental consent is required by law if the minor is not accompanied by a parent. For families with dual insurance coverage, a birthday law applies. The birth date (birth month) of the parent that falls first in the year becomes primary.

Other Fees:
In the event that you need copies of your medical records, a copy fee will be charged, unless the records are requested by a physician. Payment due prior to receipt of records. We accept cash, checks, Visa, MasterCard, and Discover.

SIGNATURE OF ACKNOWLEDGMENT:
I realize that I am responsible for payment of all medical services rendered to me and/or my dependents, regardless of the decision of reimbursement made by my insurance carrier.
I have read the above and acknowledge that I am aware of the practice's Financial Policy.
I authorize payment from my insurance carrier(s) for medical and/or surgical benefits to the treating physician.
I further authorize my physician to release any and all information necessary concerning my diagnosis and treatment for the purpose of securing payment from my insurance carrier(s).
NOTE: Your signature below will remain in effect unless written consent is received to revoke your authorization.

Signed (Patient or Parent if minor) _____ **Date**_____

PROTECTED HEALTH INFORMATION RELEASE

I, _____, hereby authorize the release of my medical information to: _____
(State relationship to patient and full name of party/parties authorized to receive medical information.)

By signing this form, you authorize the Practice to use and disclose protected health information about you for reasons you have been made aware of. You have the right to revoke this authorization at any time, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior authorization. Should you want to revoke disclosure of any information in your chart, please submit in writing.

Signed _____ **Date:** _____ **Witness:**_____ **Date:** _____