PATIENT INFORMATION RECORD

PATIENT INFORMATION (Please Print)

Patient Name	Sex M F	Marital Status S M W D SEP	Date of Birth
Address (including City, State, Zip Code)			Social Security Number
Email	Home Phone	Cell Phone	Work Phone
Patient's Occupation		Employer	

Spouse's Name	Spouse's Date of Birth	Social Security Number
Spouse's Occupation	Spouse's Employer	Spouse's Contact Number
Emergency Contact	Emergency Contact Relationship	Emergency Contact Phone

IF MINOR OR STUDENT, PLEASE FILL INFO BELOW

Mother's Name	Date of Birth	Social Security Number
Address (including City, State, Zip Code)	Occupation	Contact Number
Father's Name	Date of Birth	Social Security Number
Address (including City, State, Zip Code)	Occupation	Contact Number

We are willing to act as your agent in obtaining maximum benefits from your insurance company. We will contact your insurance company and obtain benefit information which will be applied to your bill.

Please be aware of the following:

- ***Not all insurance companies provide vision care.***
- ***Vision care insurance covers eye exams and/or glasses and contact lenses.***
- ***Major medical insurance covers eye problems (i.e. conjunctivitis), eye injuries and diseases (i.e. cataracts, glaucoma, etc.)***
- ***Many times vision care insurance plans and major medical insurance plans are covered by different companies.***
- ***We will submit claims for services provided to your insurance company, but you are ultimately responsible for the amounts that your insurance company does not cover.***
- ***Depending on your plan or coverage, you may be instructed to pay at the time services are rendered and receive reimbursement from your insurance company.***

Please fill out the following information so that we may obtain benefit information and submit your claim to your insurance carrier:

Patient Name	**Patient Date of Birth**	**Patient Social Security #**
Insured Person's Name	**Insured's Date of Birth**	**Insured's Social Security#**
Patient's relationship to Insured	**Medical Insurance Name**	**Medical Insurance ID Number**
Self Spouse Child Other		
Insured Person's Employer	**Vision Insurance Name**	**Vision Insurance ID Number**

- ***I authorize the use of this form on all insurance transactions.***
- ***I authorize release of information to all my insurance carriers.***
- ***I authorize my doctor to act as my agent in helping me obtain payment from my insurance carriers.***
- ***I authorize payment directly to my doctor should he/she accept assignment for such.***
- ***I understand that I am ultimately responsible for the portion of my bill that my insurance does not cover.***
- ***I understand that I am responsible for my bill if my insurance doesn't pay or respond to claims within 30 days.***

Signature:_____ Date:_____

PATIENT CONSENT FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

Privacy Policy

Our "Notice of Privacy Practices" provides information about how we may use and disclose protected health information about you. The notice contains a "Patient Rights" section describing your rights under the law. You have the right to review our notice before signing this consent. The terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Consent to Release Information

By signing this form, I permit the practice to release any medical information to the physicians involved in my care. I consent that the practice may call my house or other designated locations and leave a message on voicemail or in person in reference to appointment reminders and insurance items. In addition, the practice may mail to my home appointment reminders and patient statements.

I designate the following representative(s) who the doctor or clinical staff can communicate with on my behalf. If I do not designate anyone, I understand that the doctor or clinical staff will be unable to speak with anyone regarding my medical condition.

Name_____Relationship_____Phone #_____

Name_____Relationship_____Phone #_____

Name_____Relationship_____Phone #_____

Name_____Relationship_____Phone #_____

Signature on File:

Signature of Patient or Legal Guardian_____

Print Patient's Name_____Date_____

Print Legal Guardian's Name_____

Please let us know if you would like to review "Notice of Privacy Practices".

HEALTH HISTORY QUESTIONNAIRE

Your Primary Care Physician _____ Physician's Tel:_____

When was your last *Health* exam?_____ When was your last *Eye* exam?_____

□ Male □ Female

History of Major Illnesses/Injuries

History of Surgeries	Date	Surgeon
Eye:		
Other:		

Current Medications & Eyedrops	Reason for Taking

DRUG ALLERGIES	

Your Current Eye Symptoms	Yes	No
Glaucoma		
Cataract		
Macular degeneration		
Retinal detachment		
Color Blindness		
Headaches		
Glare/light sensitivity		
Tired eye		
Lazy eye		
Burning		
Dryness		
Excess tearing		
Eye pain or soreness		
Foreign body sensation		
Infection of eye		
Itching		
Mucous discharge		
Droopy eyelid		
Redness		
Sandy or gritty feeling		
Crossed eyes		
Blurred vision distance		
Blurred vision near		
Distorted Vision		
Double Vision		
Floaters or spots		
Fluctuating Vision		
Loss of Vision		
Loss of Side Vision		

Your Medical History	Yes	No
Allergies (seasonal)		
Excessive Weight Loss/Gain		
Ears, nose, throat		
High Blood Pressure		
High Cholesterol		
Asthma/Breathing Problems		
Stomach Problems		
Arthritis/Osteoporosis		
Skin (acne, rashes, etc.)		
MS/Seizures		
Anxiety, depression		
Kidney Problems		
Diabetes		
Thyroid Problems		
Anemia/Blood Disorders		
HIV/Herpes/Lyme		
Cancer: type:		
Other specify		
Are you pregnant/nursing?		

Your Family History			
Eye Diseases	Yes	No	Who
Lazy eye			
Eye tumor			
Blindness			
Cataract(s)			
Color Blindness			
Glaucoma			
Macular degeneration			
Retinal detachment			
Arthritis			
Cancer			
Diabetes			
Heart Disease			
High Blood Pressure			
High Cholesterol			
Stroke			
Kidney Disease			
Lupus			
Thyroid Disease			
Other:			

Your Social History	
Current Occupation:	
Computer Use? Y or N Hrs/Day:	Exercise? Y or N Times per Week:
Do you wear glasses? Y or N If Yes: Full time or Part time? Type of glasses owned:	Do you use vitamins? Y or N Drink Alcohol? Y or N Drinks per week:
Do you wear contacts? Y or N If yes: what type	Smoke? Y or N 1/2/Pk 1/Pk 1+/Pk Day/Week
Hobbies/Interests (Circle): Golf/Tennis/Baseball/Fishing/Hiking/Jogging/Other:	

Patient Signature: x_____ Print Name: _____ **Date:**_____

Date	Changes Y/N	PT Initial	Date	Changes Y/N	PT Initial	Date	Changes Y/N	PT Initial