EYECARE ASSOCIATES PATIENT INFORMATION

NAME _____ PREFERRED NAME_____ DATE_____

HOW WERE YOU REFERRED TO US _____ MARITAL STATUS _____

ADDRESS_____ CITY _____STATE _____ ZIP _____

E-MAIL_____

BIRTH DATE _____ GENDER _____ SOCIAL SECURITY NUMBER XXX - XX- _____

HOME PHONE _____WORK PHONE _____

CELL PHONE_____ EMPLOYER _____

VISION INSURANCE _____INSURED NAME _____

MEDICAL INSURANCE _____ INSURED ID _____

SPOUSE / PARENT _____ EMPLOYER _____

MEDICAL HISTORY

REASON FOR TODAY'S VISIT_____

LIST ANY SIGNIFICANT MEDICAL PROBLEMS_____

_____

LIST ANY MEDICATIONS YOU TAKE REGULARLY_____

LIST ANYTHING YOU ARE ALLERGIC TO _____

DO YOU *OR* ANY MEMBER OF YOUR FAMILY HAVE A HISTORY OF EYE SURGERY, CATARACTS, GLAUCOMA, MACULAR DEGENERATION, DIABETES, OR HYPERTENSION? IF SO, EXPLAIN_____

_____

I CURRENTLY WEAR: □ EYEGLASSES □ SUNGLASSES □ CONTACTS. **NOTE TO CONTACT LENS WEARERS**:

A COMPREHENSIVE EYE EXAM DOES NOT INCLUDE CONTACT LENS SERVICES. THE FITTING OF CONTACT LENSES REQUIRES ADDITIONAL TIME AND TESTING. A SEPARATE FEE WILL BE CHARGED. _____ (INITIAL)

WHAT TYPES OF HOBBIES DO YOU ENJOY OR PARTICIPATE IN? _____

DO YOU PARTICIPATE IN A FLEXIBLE SPENDING PLAN OR HEALTH SAVINGS ACCOUNT? YES ___ NO ___

INSURANCE/HIPAA

I acknowledge that I have access to a copy of the office's Notice of Privacy Practices, and that my medical information will be kept confidential. I, the patient, KNOW MY INSURANCE COVERAGE. I authorize my insurance to be billed and I authorize payment to the physician herein for medical services rendered. I authorize the physician to release any information required in the processing of insurance. Co-payments and deductibles are due at time of service. I understand my deductible must be paid before my insurance will pay. My insurance may be billed for me but in the event insurance does not pay in full within 60 days for *any reason* all amounts due are my responsibility after that time and expected to be paid in full within 15 days. A service charge of 1.5% of the balance may be added to amount past due over 60 days and a service fee of $20 may be added for returned checks. Should my balance be turned over to a Collections Agency, I understand there will be a 40% collections fee and any reasonable attorney's fee added to my balance. Any Materials ordered and not picked up within 60 days will be returned to stock and the deposit forfeited. A photocopy of this signature is valid as the original. **I HAVE READ THE ABOVE POLICIES AND AGREE:**

SIGNATURE _____ DATE_____