

**PATIENT INFORMATION**

**Patient Name (Last, First, MI)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Date of Birth**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_ Patient SSN**\_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_ **M/F**

**Street Address**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **City**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **State**\_\_\_\_\_ **Zip**\_\_\_\_\_\_\_\_

**Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work** **Phone**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Cell Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email Address**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Please star the best way for us to contact you

**Employer (or School)**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Occupation (or Grade)**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient resides with (minor)**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Parent Name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parent Date of Birth**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Parent’s Employer**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE INFORMATION**

We will need to scan a copy of your vision plan and medical insurance cards

**Vision Plan**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **ID#** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Member’s Information: (If not patient)**

**Name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB**\_\_\_\_\_\_\_\_\_\_ **SSN**\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_

**Employer** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Insurance**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **ID#** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Member’s Information: (If not patient)**

**Name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB**\_\_\_\_\_\_\_\_\_\_ **SSN**\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_ **Employer** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT HEALTH HISTORY**

**Please circle or specify any of the following for which you have been diagnosed or are being treated:**

**Y/N Eye:** Cataracts Macular Degeneration Glaucoma Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Y/N Ears/Nose/Throat:**  Vertigo Sinusitis Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Y/N Neurological**: Parkinson’s Seizures Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Y/N Psychiatric**: Depression ADHD Anxiety Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Y/N Cardiovascular:** High BP High Chol Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Y/N Lungs**: Asthma COPD Emphysema Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Y/N Gastrointestinal**: Ulcers Crohn’s Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Y/N Genitourinary:** Kidneys Ovaries Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Y/N Muscle/Bone**: Arthritis Fibromyalgia Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Y/N Skin:** Rosacea Eczema Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Y/N Endocrine:**  Diabetes Thyroid Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Y/N Blood:** HIV Sickle Cell Anemia Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*Diabetic patients: Type 1 or Type 2 (please circle)**

 **Year of Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_ Controlled: Y/N**

 **Blood sugar range: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last A1c: \_\_\_\_\_\_\_\_\_\_\_**

 **Follow up schedule with PCP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Current Primary Care Physician or Pediatrician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you use cigarettes/tobacco/alcohol? YES/NO Are you or could you be pregnant? YES/NO**

**CURRENT MEDICATIONS**

**\*Please include all vitamins and supplements\***

**(We would be glad to copy a list)**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Eye Drops: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Allergies to Medications YES/NO** If yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY HISTORY/RELATIONSHIP**

**Please circle yes or no if any of the following family members have/had any condition below. If YES please specify which family member.**

**Mother, Father, Sister, Brother, Maternal Grandmother/Grandfather, Paternal Grandmother/Grandfather**

**Cancer YES/NO \_\_\_\_\_\_\_\_\_\_\_\_ Cataracts YES/NO\_\_\_\_\_\_\_\_\_\_\_\_**

**Diabetes YES/NO \_\_\_\_\_\_\_\_\_\_\_\_ Macular-**

**High Blood Pressure YES/NO \_\_\_\_\_\_\_\_\_\_\_\_ Degeneration YES/NO\_\_\_\_\_\_\_\_\_\_\_\_**

**Heart Disease YES/NO \_\_\_\_\_\_\_\_\_\_\_\_ Glaucoma YES/NO\_\_\_\_\_\_\_\_\_\_\_\_**

**Cholesterol YES/NO \_\_\_\_\_\_\_\_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please initial and date to confirm that you have verified all the above information is correct on the day of your visit.**

**Patient: \_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_ Dr. \_\_\_\_\_\_ Tech \_\_\_\_\_\_\_\_\_**

**Patient: \_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_ Dr. \_\_\_\_\_\_ Tech \_\_\_\_\_\_\_\_\_**

**Patient: \_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_ Dr. \_\_\_\_\_\_ Tech \_\_\_\_\_\_\_\_\_**

**Patient: \_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_ Dr. \_\_\_\_\_\_ Tech \_\_\_\_\_\_\_\_\_**

**Patient: \_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_ Dr. \_\_\_\_\_\_ Tech \_\_\_\_\_\_\_\_\_**

**Patient: \_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_ Dr. \_\_\_\_\_\_ Tech \_\_\_\_\_\_\_\_\_**

**NOTICE OF PRIVACY PRACTICES**

We will use and disclose your personal health information to treat you, to receive payment for the care we provide, and for referral care if needed. We have a laminated copy of our privacy policy attached to the clip board and can also print a copy for you to take home if you would like. The terms of the privacy policy may change with time and we will always post the current notice in our office and have copies available. I acknowledge that I have received a copy of the NOTICE OF PRIVACY PRACTICES. I authorize Dr. Nate Optometrist to furnish information to other physicians, insurance carriers and other related entities concerning the treatment and care of my dependent or myself.

Patient/Guardian Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If there is a specific person not associated with your eye care treatment you authorize our office to share your information with (Ex: spouse, family member, friend) please list their first and last name here: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PAYMENT**

Most insurance policies pay only a portion of your total charges. If you have any questions about your coverage, please contact your representative. We do not guarantee the accuracy of benefit information given to us by insurance companies! Please understand that financial responsibility for your account is yours, not the responsibility of your insurance company. I authorize the release of any medical or other information necessary to process insurance claims. I authorize payment of medical or vision benefits either to the physician or supplier of services rendered or to myself if the provider does not accept assignment. I understand that I am responsible for any balance my insurance does not pay. Should the account be referred to collections, the undersigned shall pay reasonable attorney’s fees, court costs and collecting expenses.

Signed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship (minor) :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_