PATIENT INFORMATION: **DATE:** ______________________

First Name: ______________________ Last Name: ______________________ Preferred Name: __________

Street Address: ______________________ City: ______________________ State: ______ Zip Code: __________

Home Phone #: ______________________ Cell Phone #: ______________________ Sex: Male Female Pronoun(s): ______

Date of Birth: ______________ Age: _____ Email Address: ______________________ Can we send you updates? Y N

Occupation: ______________________ Employer: ______________________

Marital Status: Single / Married / Divorced / Widowed Do you? (check all that apply) Smoke ___ Drink ___ Use Recreational Meds ___

Primary Care Doctor: ______________________ Date of Last Visit: ____________ Date of Last Eye Exam: ______________

Emergency Contact: ______________________ Phone #: ______________________

What is your primary reason for visiting us today?: ____

Are you interested in Contact lenses?: Y N Have you previously worn contacts?: Y N If yes, what brand do you use?: ______________

Do you use a computer during your day?: Y N How many hours?: _______ Do you have strain while using the computer?: Y N

Do you suffer from dry eye (gritty, burning, watery, etc.) while on the computer or any other time of the day?: Y N

Are you interested in LASIK and other refractive surgeries?: Y N Hobbies/Special visual needs: ______________________

INSURANCE INFORMATION:

Vision Insurance Provider: ______________________ Member ID #: ______________________

Medical Insurance Provider: ______________________ Member ID #: ______________________

Policy Holder: ______________________ Policy Holder's Date of Birth: ____________ Policy Holder's Last 4 SSN: __________

PATIENT'S MEDICAL HISTORY: (check all that apply) No Known Medical History ___

Diabetes: Type I ___ Type II ___ How long Diabetic? _________ Last a1c reading?: ________ Pregnant/Nursing (circle one)

High Blood Pressure	___	Ear/Nose/Mouth	___	Muscle/Joint	___	Retinal Detachment	___
Asthma/COPD	___	Heart Attack	___	Anxiety/Depression	___	Lazy Eye/Eye Turn	___
Gastrointestinal	___	HIV/AIDS	___	Blindness	___	Eye Trauma	___
Neurological	___	High Cholesterol	___	Glaucoma	___	Flashes/Floaters	___
Thyroid	___	Cancer	___	Cataracts	___	Itchy Eyes	___
Stroke	___	Headaches/Migraines	___	Macular Degeneration	___	Seasonal Allergies	___

Past Surgeries / When?: ____

Current Medications: ____

____

Are you allergic to any medications? Y N If yes, list: ____

FAMILY MEDICAL HISTORY: (check all that apply) No Known Medical History ___

Diabetes	___	Thyroid	___	Cancer	___	Glaucoma	___
High Blood Pressure	___	Stroke	___	Headaches/Migraines	___	Cataracts	___
Asthma/COPD	___	Ear/Nose/Mouth	___	Muscle/Joint	___	Macular Degeneration	___
Gastrointestinal	___	Heart Attack	___	Anxiety/Depression	___	Retinal Detachment	___
Neurological	___	High Cholesterol	___	Blindness	___	Lazy Eye/Eye Turn	___

PLEASE CONTINUE TO BACK

HIPAA POLICY/DISCLAIMER:

I have read and understand the HIPAA policy (effective April 14, 2003) presented before me. I understand that all information and correspondence regarding my health care will remain confidential. I am fully responsible for any and all follow up care that may be recommended by the health care professional.

Patient signature: ____ **Date:** _________________________

INSURANCE DISCLAIMER:

Thank you for choosing Accuvision Eye Care. We really appreciate your business! Because we accept a wide variety of insurance plans with many restrictions imposed by the insurance companies, we want to make sure you understand your responsibilities as an insurance-based customer. We will make our best effort to work with your insurance plan.

You are responsible for:

- √ Confirming that you are currently eligible for the insurance benefits
- √ Providing us with the most current information about your vision coverage
- √ Informing us of any co-payments that you are required to pay

The provisions of your insurance policy may change from one date of service to the next. Please make sure that you are aware of changes so that you can maximize your current benefits. Your insurance company can assist with this.

Sometimes, following an examination, an insurance carrier may not reimburse us for the expected amount (e.g. because you are no longer covered or because you purchased a non-covered item/service). If this happens, you will be responsible for the unpaid balance. This will be billed directly to you.

We apologize that the complexities of vision insurance makes it necessary for you to confirm your understanding of this policy. Your signature below indicates that you understand and comply with our Customer Responsibility Policy. Thank you for giving us the opportunity to satisfy your eye care needs.

Patient signature: ____ **Date:** _________________________

REFUNDS WILL NOT BE GIVEN FOR SERVICES RENDERED.

WE ALLOW 90 DAYS FOR YOU TO RETURN TO OUR OFFICE IF YOU ARE NOT SATISFIED FOR A RECHECK.