EYECARE ASSOCIATES

Patient Name: First_____ **MI** __ **Last**_____

Date of Birth: _____/_____/_____ **Sex:** M F **Social Security #:** _____

Address: _____**City**_____**State**_____**Zip**_____

Home Phone: (_____)_____**Cell Phone:** (_____)_____**Work Phone:** (_____)_____

Race (circle one): Hispanic, White, American Indian, Asian, Black/African American, Native American, Other

Ethnicity (circle one): Hispanic or Latino, Not Hispanic or Latino (Caucasian), Native American, Arab, Black/African American, Native Hawaiian or other Pacific Islander, Other

Preferred Language (circle one): English, Spanish, Arabic, French, Other

Email Address (for appointment reminders and notification of glasses and contacts): _____

Communication Preferences: Home Phone Cell Phone Work Phone Email Postal

Can we leave a message regarding test results? ____ (Y/N)

Employer: _____**Occupation:**_____

If Minor, Name of Guardian: _____

If Married, Spouse's Name: _____

In the event of an *emergency* whom can we contact? _____

Phone (_____) _____

Whom may we thank for referring you to our office? Friend/Family member_____

Phonebook_____SearchEngine_____Website_____

Insurance Listing_____ Newspaper_____Other_____

Health Insurance Portability and Accountability Act-HIPAA We respect the legal obligation to keep your health information private. The most common reason why we use or disclose your health information is for treatment, payment, or health care operations. If you would like a copy of our Notice of Privacy Practice please let the front desk know. By signing below it means that you are aware of our privacy practices and that you have been given the opportunity to obtain a copy of our policy.

***Signature:** _____**Date:**_____

Payment Information Payment is expected at the time services are rendered. Accounts left unpaid after 120 days will automatically be turned over for collections along with a $35 service charge. I understand that I will receive a statement after 30 days if the insurance has not paid. I further understand that I am responsible for the total amount due or any amount unpaid by the insurance. Any denial or dispute of payment by my insurance company is my responsibility. If insurance is being billed by our office, this signature serves as your "signature on file".

***Signature:** _____**Date:** _____

Authorization for Release of Information Many of our patients allow family members to call and request medical or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to a family member, you must list the family/friend and sign below. I authorize Eyecare Associates to release my medical and/or billing information to the individuals listed below. I understand I have the right to revoke this authorization at any time and that I have the right to inspect or receive a copy of the PHI to be disclosed.

1._____ Relation to patient: _____

2._____ Relation to patient: _____

***Signature:** _____**Date:**_____

VISION HISTORY

Date of last eye exam: _____/_____/_____ Previous eye doctor or clinic: _____

Do you currently wear: (please circle) Glasses Contacts

Are you currently using medication eye drops? (please list)_____

Any concerns about your eyes or your vision? _____

	SELF	FAMILY MEMBER(S)		SELF	FAMILY MEMBER(S)
Glaucoma			Amblyopia		
Macular Degeneration			Eye Turns		
Cataracts			Eye Surgeries		
Diabetic Eye Disease			Eye Allergies		
Retinal Detachments			Eye Injuries		
Keratoconus			Eye Infections		
Please describe any conditions marked above:					

HEALTH HISTORY

Patient Information: Height_____ Weight_____ **Primary Care Physician:_____**

Smoking Status: (please circle) Current smoker Former Smoker Never Smoked Smokeless Tobacco User

Women of childbearing age: are you currently pregnant or nursing?_____

	SELF	FAMILY MEMBER(S)		SELF	FAMILY MEMBER(S)
Digestive System			Musculoskeletal (arthritis, joint pain, etc.)		
Blood / Lymph			Respiratory (asthma, emphysema, etc.)		
Ear / Nose / Throat			Nervous System (headaches, MS, seizures, etc.)		
Allergies / Immune system			Endocrine (thyroid, diabetes, etc.)		
Skin			Cardiovascular (cholesterol, high blood pressure, etc.)		
Mental / Psychiatric			Genitourinary (kidney, bladder, etc.)		
Please describe any conditions marked above:					
Please list all medications:					
Please list all medication allergies:					

Thank you and welcome to our practice!