WELCOME

We are pleased to welcome you to Premier Eyecare. Please take a few minutes to fill out this form as completely as you can. If you have questions we will be glad to help you.

PATIENT INFORMATION

Date: _____

Patient Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

E-Mail Address: _____

Preferred Name: _____ Gender: ☐ M ☐ F

Age: _____ Birthdate: _____ SS#: _____

☐ Single ☐ Married ☐ Widowed ☐ Divorced

Occupation: _____

Employer: _____

Employer Address: _____

Employer Phone: _____

Spouse's Name: _____

Age: _____ Birthdate: _____ SS#: _____

Occupation: _____

Spouse's Employer: _____

Whom may we thank for referring you?

_____

INSURANCE

Who is responsible for your account?

_____

Relationship to patient

_____

Vision Insurance Co. _____

Subscriber Name: _____

Birthdate: _____ SS#: _____

ID#: _____

Medical Insurance Co. _____

Subscriber Name: _____

Birthdate: _____ SS#: _____

ID#: _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. Larry Toal all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

_____
Responsible Party Signature

_____ _____
Relationship Date

PAYMENT

Please check your method of preferred payment today: ☐ Cash ☐ Check ☐ Debit ☐ Mastercard / Visa ☐ Discover ☐ AMEX

Payment is expected in full at the time services are provided. A 50% deposit is required on all materials ordered. Balances are due at the time materials are dispensed.

Personal Medical Information: Do you have problems with any of these systems? If Yes, please check the box.

☐ Gastrointestinal	☐ Respiratory	☐ Genitourinary	☐ Mental	☐ Allergic/Immunologic
☐ Ear/Nose/Throat	☐ Headaches	☐ Musculoskeletal	☐ Endocrine	☐ Surgeries (what type & when)
☐ Cardiovascular	☐ Nervous System	☐ Skin	☐ Blood/Lymph	_____

Have you been diagnosed with:

Diabetes? ☐ Yes ☐ No

Glaucoma? ☐ Yes ☐ No

Macular Degeneration? ☐ Yes ☐ No

Are You Pregnant? ☐ Yes ☐ No Currently Nursing? ☐ Yes ☐ No

Are you in good health? ☐ Yes ☐ No

Name of general physician: _____

PLEASE CONTINUE TO THE NEXT PAGE

Do you have family history of the following?
If Yes, please check the box.

- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Glaucoma
- ☐ Retinal Detachment
- ☐ Cataracts
- ☐ Macular Degeneration

Please explain any boxes you have checked

_____

_____

_____

Do you have any of the following?
If Yes, please check the box.

- ☐ Dry Eyes
- ☐ Eye Injuries
- ☐ Blurred Vision
- ☐ Wear Glasses
- ☐ Eye Surgeries
- ☐ Wear Contacts

Any eye problems at this time? Please explain:

_____

_____

_____

Do you smoke? ☐ Yes ☐ No How Much? _____

Do you drink alcohol? ☐ Yes ☐ No How Much? _____

Name of Previous Eye Doctor: _____ Date of Last Eye Exam: _____

MEDICATIONS/VITAMINS/OTC

List all medications you are currently taking, including eye drops:

_____

_____

_____

_____

Pharmacy Name: _____

Phone: _____

ALLERGIES

List your allergies to medications or other substances:

_____

_____

_____

_____

_____

_____

RECEIPT OF NOTICES OF PRIVACY POLICIES & CONSENT FORM

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct health care operations involving our office.

I have read this document and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations. I acknowledge that I have received the Notice of Privacy Practices from Premier Eyecare.

_____ _____

Signature of Patient (Parent if under 18) **Date**

THANK YOU