

Patient Information

<p>Date: _____ (please circle one) Dr. Mr. Mrs. Ms. Miss</p> <p>_____ First MI Last</p> <p>Address _____</p> <p>City _____ State _____ Zip _____</p> <p>Home Phone _____ Cell Phone _____</p> <p>Birthdate (mo/day/year) _____ - _____ - _____ Social Security # _____</p> <p>Emergency Contact Name _____ Phone _____</p> <hr style="border-top: 1px dashed black;"/> <p><u>Employment Information</u> (if applicable)</p> <p>Occupation: _____</p> <p>Employer: _____</p> <p>Employer Address: _____</p> <p>City, State, Zip: _____</p> <p>Employer Phone #: _____</p>	<p><u>Billing Information</u> (Complete this section if Person Responsible is <u>NOT</u> the patient. This is <u>NOT</u> the Insurance Company Info.)</p> <p>Name: _____</p> <p>Address: _____</p> <p>City, State, Zip: _____</p> <p>Home Phone: _____</p> <p>Work Phone: _____</p> <p>Birthdate: _____</p> <p>Social Security #: _____</p> <p>Relationship to Patient: _____</p> <hr style="border-top: 1px dashed black;"/> <p><u>**Primary Insurance Information**</u></p> <p>Insurance Company Name _____ Plan Name _____</p> <p>Insurance ID # _____ Group # _____</p> <p>Policy Holder's Name _____ Policy Holder's Birthdate _____</p> <p>Relationship to patient _____</p> <p style="text-align: center;"><i>*Please show your Insurance Card(s) to a member of our Staff.</i></p>
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I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR CHARGES NOT COVERED BY MY INSURANCE. I authorize *Insight Eye Care, LLC* to furnish my insurance company all pertinent information. I authorize benefits to be paid directly to *Insight Eye Care, LLC*. I am responsible for providing any referrals required by my insurance. I agree to pay all interest charges, collection fees, and/or attorney fees/court costs if any delinquent balance is placed with a collection agency. I understand there is a \$20.⁰⁰ service charge for all returned checks. I understand that appointments not cancelled prior to appointment time may be subject to a \$25.⁰⁰ missed appointment fee.

I DECLARE THAT I HAVE PROVIDED ALL THE MEDICAL/HEALTH INFORMATION PLANS FROM WHICH I MAY RECEIVE BENEFITS.

I further acknowledge that a copy of *Insight Eye Care, LLC's* **Notice of Privacy Practices** was provided to me. I also acknowledge and understand that if I have any questions about *Insight Eye Care, LLC's* privacy practices or my rights with regard to my personal health information, I may contact *Insight Eye Care, LLC's* Privacy Officer for further information as set forth in the Notice.

 Signature of Patient (or Patient's Representative)

 Date

 (Relation to patient, if signed by Patient's Representative)

MEDICAL HISTORY

Name: _____ Birthdate: _____

Personal Medical History

(None of the below)

- High Blood Pressure
- Heart Disease
- Diabetes (how long? _____)
- Asthma/Emphysema
- Seasonal Allergies
- Neurological Condition
- Thyroid Disease
- AIDS/HIV
- Migraines
- Rheumatoid Arthritis
- Multiple Sclerosis
- Other: _____

Personal Eye History

(None of the below)

- Glasses
- Contacts
- Eye Injury
- Eye Surgery (lasik, cataract, etc.)
- Lazy Eye
- Crossed Eyes
- Vision Therapy
- Glaucoma
- Cataracts
- Keratoconus
- Other: _____
- Retinal Detachment
- Diabetic Retinopathy
- Macular Degeneration

Current Symptoms

(None of the below)

- Blurred Vision
- Head Ache
- Double Vision
- Eye Pain
- Dry Eyes
- Watery Eyes
- Flashing Lights
- Eye Fatigue
- Other: _____
- Floating Objects
- Loss of Vision (black out)

Family History

(None of the below)

- High Blood Pressure
- Heart Disease
- Diabetes
- Cancer
- Thyroid Disease
- Stroke
- Lazy Eye
- Crossed Eyes
- Other: _____
- Macular Degeneration
- Glaucoma

Medications (I take **NO** medications)

Prescription Meds: _____

Over-the-counter Meds: _____

Eye Drops/Meds: _____

Allergies (None Known)

Medication/Other Allergies: _____

Social History

Occupation: _____ Use a computer? No Yes (Hrs/day _____)

Hobbies/Activities: _____

Do you smoke? No Yes Do you drink alcohol? No Yes

Contact Lens History (Not Applicable)

Type of contact lenses you wear: _____ How often do you replace your lenses? _____

Do you sleep in your contacts? No Yes (if "yes", how often? _____)

Any problems with your current contact lenses? _____

Dilated Eye Exam: I understand that my eyes may be dilated in the course of my exam, and as a consequence, I may experience blurring of vision and sensitivity to light. This may make it difficult to read, drive, or carry out normal visual activities until the effect of the dilation wears off. Allergic reactions to the medications may occur but are very rare. Dark glasses will be provided at the end of the visit to provide comfort from bright light. I also understand that a dilated eye exam helps to detect serious eye conditions, however, I may ask the doctor/staff of *Insight Eye Care, LLC* to not dilate my eyes.

Signature of Patient (or Patient's Representative)

Date

Optometrist's Signature