

Mr. Ms. Miss Dr. (Please Check One)

Name _____
Address _____
City _____ State _____ Zip _____
Home Phone _____ Work Phone _____
Date of Birth _____ Social Security Number _____
Age _____ Occupation _____
Employer _____

- Referral From: _____
- Others in Family Have Been in
- From Telephone Book
- Insurance Provider List
- Other: _____

Most Recent Eye Examination:

Date: _____
Dr. _____
City _____
State _____

Primary Care Physician:

Dr. _____
Last Exam Date _____

Previous Eye Care: check all that apply

- Full time glasses
- Eye Surgery type:

- Eye Medications:

- Low Vision Aid/Magnifiers:

- Previous Low Vision Evaluation

Please check any of the following that apply to you:

- Double Vision**
- Blurred Vision**
- Eye Pain or discomfort**
- Eye turns in or out**
- Hold reading close**
- Close, cover one eye**
- Eyes frequently red**
- Lose place when reading**
- Make poor distance judgments**
- Eye or health problems in family**
- Bothered by light**

General Health Problems:

- Past severe head injury**
- Thyroid problems**
- Diabetes**
- High or low blood pressure**
- Headaches**
- Allergies**
- Sinus infections/pressure**
- Cataracts**
- Glaucoma**

Medications:

- See attached list**
-

INSURANCE AND PAYMENT INFORMATION

Primary Insurance Plan:

Name of Insurance _____
Primary Insured Name _____
Relation to Patient _____
Insured ID Number _____
Group Plan Name/Number _____

Secondary Insurance Plan:

Name of Insurance _____
Primary Insured Name _____
Relation to Patient _____
Insured ID Number _____
Group Plan Name/Number _____

Please list any additional persons you authorize to access your personal health information (PHI), including billing and medical records information:

Full Name Relationship

Full Name Relationship

Full Name Relationship

Payment is due at the time services are rendered. I will be paying today by:

Cash Check Credit/Debit Card (we accept Visa or Mastercard)

If you have insurance coverage for these services or materials and we are current providers, we will submit claims for you. *However, we are not liable for collecting your claim. After 30 days, we will expect payment in full from you if your insurance company has not paid.*

I hereby authorize my insurance carrier to make payment directly to Five Points Eye Care Center. I authorize that *I am financially responsible for all charges whether or not they are covered by insurance or other entities.* I also authorize release of any information regarding my treatment or condition in order to obtain payment for services.

I understand and agree that, regardless of my insurance status, *I am ultimately responsible for the balance of my account for any services rendered.* I have read all the information on this sheet and have completed the above questionnaire. I certify that this information is true and correct to the best of my knowledge. I agree to notify this office of any changes in my insurance status or the above information.

PATIENT SIGNATURE DATE

PARENT/GUARDIAN (IF MINOR) DATE