

WELCOME

1 PATIENT INFORMATION

Patient _____
Address _____
City State Zip
Sex: M F Date of Birth _____
Patient Status: Single Married Other
 Employed Full-Time Student Part-Time Student
Patient SS # _____
(optional)
Occupation _____
Employer _____
Employer Address _____
Primary Care Physician _____
Whom may we thank for referring you? _____

Signage Direct Mail Radio
 Internet Yellow Pages Newspaper

2 INSURANCE/RESPONSIBLE PARTY

Name of Responsible Party _____
Relationship to Patient _____
SS # _____
Primary Insurance Co. _____
Subscriber Name _____
Date of Birth _____
ID# _____
Secondary Insurance Co. _____
Subscriber Name _____
Date of Birth _____
ID# _____

ASSIGNMENT AND RELEASE

I, the undersigned, assign directly to this office all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges not paid by insurance. I hereby authorize the doctor to release all information to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature _____ Date _____

3 ACTIVITIES & SOCIAL HISTORY

Special Occupational Visual Needs _____

Hobbies _____ Sports _____

Are you interested in contact lenses? Yes No

ARE YOU INTERESTED IN LASER VISION CORRECTION?
 Yes No

Alcohol Use: Never Rarely Moderate Daily
Tobacco Use: Never Yes Previous

4 PHONE NUMBERS

HOME: _____
WORK: _____
Mobile/Cell _____
Emergency Contact Name _____
Daytime Phone _____

PATIENT SERVICE AGREEMENT

Thank you for choosing us as your eye health care provider. Prior to receiving care, read and sign the following.

OUR COMMITMENT TO YOU:

- Personalized Eye Health Care
 - Patient Education
 - Exceptional Service with Infinite Accuracy
 - Controlling Costs
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- Full payment is due at time of service.
 - A minimum of half down is required at time of order with full payment when glasses and/or contact lenses are picked up.
 - We accept cash, checks, credit cards.

INSURANCE

- Your insurance is a contract between you and your insurance company. We are not a party to that contract. We will pre-certify your coverage at the time of your visit. During pre-certification, every insurance company states, "This is not a guarantee of benefits".
- As a courtesy, we may accept assignment of insurance benefits and we will file your insurance claim for you. Be aware that some, perhaps all, of the services provided may be deemed non-covered services by your insurance company.
- If your insurance requires you to have a prior-authorization or referral, it is your responsibility to request and obtain the needed information. If you do not have one, treatment may be denied.
- The maximum we will wait for insurance reimbursement is 90 days, after which the insurance amount is then payable by you.
- Regarding insurance plans in which we are participating providers, all co-pays and deductibles are due the day service is provided, per your insurance company. You may lose privileges if you do not comply. If we are non-participating providers you are responsible for the balance.

USUAL AND CUSTOMARY RATES

- You are responsible for payment regardless of your insurance company's arbitrary determination of usual and customary fees.

MINOR PATIENTS

- The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment may be denied unless charges have been pre-authorized. It is not possible for us to do split billing between accounts.

INTEREST

- We reserve the right to charge a late fee in the amount of 1% as provided by state law for any unpaid patient balance remaining after 60 days of service.
- Collection proceedings will begin on any outstanding balance in non-compliance with this policy.

Signature of Responsible Party

Date

PATIENT HEALTH HISTORY

PLEASE CIRCLE YES OR NO

Name: _____

Date: _____

FAMILY (blood relatives) HEALTH HISTORY

Cataract	No	Yes	Diabetes	No	Yes	List any other Health Problems that run in your Family _____ _____ _____ _____
Glaucoma	No	Yes	High Blood Pressure	No	Yes	
Macular Degeneration	No	Yes	Heart Problems/Stroke	No	Yes	
Blindness	No	Yes	Thyroid Problems	No	Yes	
Retinal Detachment	No	Yes	Cancer	No	Yes	
Other _____			Arthritis	No	Yes	

SELF - OCULAR HISTORY

Date of previous eye exam: _____

Cataract	No	Yes	Injury to Eye or Head	No	Yes	Eye Infections	No	Yes
Glaucoma	No	Yes	Ocular Foreign Body Removed	No	Yes	Other _____		
Macular Degeneration	No	Yes	Explain _____			Eye Surgery	No	Yes
Blindness	No	Yes	Amblyopia (Lazy Eye)	No	Yes	Explain _____		
Retinal Detachment	No	Yes	Strabismus (Eye Turn)	No	Yes			

SELF - HEALTH HISTORY / ROS

Name of Regular Physician: _____

<input type="checkbox"/> Constitutional Symptoms	Developmental Disability	No	Yes	<input type="checkbox"/> Genitourinary	Urinary Tract Infections	No	Yes
	Recent Weight Change	No	Yes		Kidney Problems	No	Yes
	Fever	No	Yes		STD's (HIV, Herpes, Chlamydia)	No	Yes
	Fatigue	No	Yes		Onset Date: _____		
	Shortness of Breath	No	Yes		Comment: _____		
	Date: _____			<input type="checkbox"/> Endocrine	Non-insulin Dependent Diabetes	No	Yes
	Comment: _____				Insulin Dependent Diabetes	No	Yes
<input type="checkbox"/> Ears / Nose / Mouth / Throat	Chronic Sinus Problems	No	Yes		Thyroid Problems	No	Yes
	Hearing Loss	No	Yes		Onset Date: _____		
	Onset Date: _____				Comment: _____		
	Comment: _____			<input type="checkbox"/> Musculoskeletal	Arthritis	No	Yes
<input type="checkbox"/> Respiratory	Asthma/Bronchitis	No	Yes		Fibromyalgia	No	Yes
	Emphysema	No	Yes		Muscular Dystrophy	No	Yes
	Onset Date: _____				Onset Date: _____		
	Comment: _____				Comment: _____		
<input type="checkbox"/> Hematologic / Lymphatic	Anemia	No	Yes	<input type="checkbox"/> Neurological	Multiple Sclerosis	No	Yes
	Leukemia	No	Yes		Epilepsy	No	Yes
	Large Volume Blood Loss	No	Yes		Onset Date: _____		
	Onset Date: _____				Comment: _____		
	Comment: _____			<input type="checkbox"/> Psychiatric	Depression	No	Yes
<input type="checkbox"/> Cardiovascular	Heart Problems	No	Yes		Nervousness/Panic Disorder	No	Yes
	High Blood Pressure	No	Yes		Schizophrenia	No	Yes
	Stroke	No	Yes		Onset Date: _____		
	Onset Date: _____				Comment: _____		
	Comment: _____			<input type="checkbox"/> Allergic / Immunologic	HIV/AIDS	No	Yes
<input type="checkbox"/> Gastrointestinal	Crohn's Disease	No	Yes		Lupus	No	Yes
	Ulcer	No	Yes		Cancer	No	Yes
	Onset Date: _____				Environmental/Food Allergy	No	Yes
	Comment: _____				Onset Date: _____		
					Comment: _____		

PATIENT DRUG ALLERGIES OR SENSITIVITIES

Granite Family Eyecare

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

You May Refuse to Sign This Acknowledgment

I, _____, have received a copy of this
office's Notice of Privacy Practices.

Please Print Name

Signature

Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgment
- An emergency situation prevented us from obtaining acknowledgment
- Other (please specify)

