Patient Information and Insurance Coverage

Today's Date_____

Patient Name _____ Birthdate _____

Street Address _____ Apt. Number_____

City _____ State _____ Zip _____ Full time student? Yes No

By providing your phone numbers and email, you agree to phone calls, messages, texts and emails from our office.

Home Phone_____ Work Phone _____ Cell Phone _____

E-mail Address _____

Social Security Number _____ Sex _____ Marital Status _____

Occupation_____ Employer _____

Responsible Party (person responsible for any balance due on this patient's account if other than the patient)

Fill in any information that is different from above.

Name _____ Birthdate _____

Street Address _____ Apt. Number_____

City _____ State _____ Zip _____

By providing your phone numbers and email, you agree to phone calls, messages, texts and emails from our office:

Home Phone_____ Work Phone _____ Cell Phone _____

E-mail Address_____

Primary Vision Insurance: (Please print neatly.)

Policy Holder Name _____ Date of Birth_____/_____/_____

Address (if different from patient) _____

Social Security Number or Insurance ID Number_____ Relationship to patient _____

Name of Insurance Company _____ Employer _____

Group or Plan Number _____

Secondary Vision Insurance: (Please print neatly.)

Policy Holder Name _____ Date of Birth_____/_____/_____

Address (if different from patient) _____

Social Security Number or Insurance ID Number_____ Relationship to patient _____

Name of Insurance Company _____ Employer _____

Group or Plan Number _____

Primary <u>Medical</u> Insurance: (Please print neatly.)

Policy Holder Name _____ Date of Birth_____/_____/_____

Address (if different from patient) _____

Social Security Number or Insurance ID Number_____ Relationship to patient _____

Name of Insurance Company _____ Employer _____

Group or Plan Number _____

Secondary <u>Medical</u> Insurance: (Please print neatly.)

Policy Holder Name _____ Date of Birth_____/_____/_____

Address (if different from patient) _____

Social Security Number or Insurance ID Number_____ Relationship to patient _____

Name of Insurance Company _____ Employer _____

Group or Plan Number _____

NO INSURANCE: I am not providing any insurance information. I agree to pay 100% of charges for services and materials at the time of service.

Responsible Party Signature_____ Date: _____

Patient Name: _____ DOB: _____ Today's Date: _____

Race:
_____ Asian
_____ Black/African-American
_____ Hispanic
_____ White/Caucasian
_____ Native Hawaiian/Pacific Islander
_____ American Indian
Other: _____

Ethnicity:
_____Hispanic/Latino ____Not Hispanic/Latino
_____Native Hawaiian/Pacific Islander

Preferred Language:
_____ English ____ Spanish _____Other: _____

Social History:
Current smoker No Yes How long you have smoked? _____
Past Smoker No Yes Stopped when? _____

Medical History:

Allergies:	No	Yes	Diabetes:	No	Type 1	Type 2	
Thyroid Disease:	No	Yes	How long? _____				
High Blood Pressure:	No	Yes	Arthritis:	No	Yes:	Rheumatoid?	No Yes
High Cholesterol:	No	Yes	Cancer:	No	Yes		
Respiratory Disease:	No	Yes	Type/when: _____				
Digestive Disease:	No	Yes	Autoimmune disorder:	No	Yes		
Head injury:	No	Yes	Type: _____				
Headaches:	No	Yes	Neurological disorder:	No	Yes		
Pregnant / Nursing:	No	Yes	Type: _____				

Add any additional information: _____
_____
_____

Patient Eye History:

Eye Surgery	No	Yes	Type: _____	When: _____
Eye Injury	No	Yes	Type: _____	When: _____
Glaucoma	No	Yes	Treatment: _____	
Cataracts	No	Yes		
Retinal disorders	No	Yes	Type: _____	Treatment: _____
Eye turn	No	Yes		
Amblyopia	No	Yes		
Keratoconus	No	Yes	Treatment: _____	
Flashes of light	No	Yes		
Floaters	No	Yes		

Do you wear glasses? No Yes Full time _____ Reading only _____ Distance only _____
If you wear contact lenses, are they: soft _____ (brand :_____) gas permeable _____

Family Eye Disease History:

Cataracts	No	Yes	Family member(s):_____
Glaucoma	No	Yes	Family member(s):_____
Retinal disease	No	Yes	Family member(s):_____
Macular Degeneration	No	Yes	Family member(s):_____
Keratoconus	No	Yes	Family member(s):_____

Medications: (You may provide a list if you prefer.)

Name of medication:	Dosage:

Medication Allergies:

Name of medication:	Type of reaction:

Primary Care Physician: _____

Location _____Phone _____ Fax_____
Do you want a report of this exam sent to your doctor? Yes No
Do you want a report of this exam sent to another doctor? If so, please provide their:

Name _____

Location _____Phone _____ Fax_____

Payment Agreement:
I understand that I am ultimately responsible for any unpaid claims and that this authorization is valid until such time that I terminate it in writing.

Print Patient Name _____ Patient Date of Birth ____/____/_____

Responsible Party Signature _____ Date ____/____/_____

Privacy Policies:
In compliance with the federal regulations of HIPAA's privacy rule, I acknowledge that I was given the opportunity to read the Notice of Privacy Policies for Pflugerville Vision Care. I understand there is a copy in its entirety on the website at www.pflugervillevisioncare.com and a written copy at the front desk. I agree to accept the policies of this office and continue my care with Pflugerville Vision Care.

Patient (or Responsible Party) Signature_____ Date _____

Authorization for Release of Identifying Health Information

This authorization gives permission to the designated person(s) named below to:
* pick up my glasses/contact lenses
*make/confirm my appointments
* have access to telephone communication including answering messages
*be made aware of my diagnosis, prognosis, and treatment plans
* have access to my financial information as it pertains to Pflugerville Vision Care
*have access to my medical records as it pertains to Pflugerville Vision Care

Patient Name: _____ **Date of Birth**: _____

Designated Party: _____ Relationship to patient: _____

Designated Party: _____ Relationship to patient: _____

Designated Party: _____ Relationship to patient: _____

Designated Party: _____ Relationship to patient: _____

Those person(s) listed below have my permission to *only* pick up my glasses/contacts with the understanding that my prescription information may be obtained from the contact lens boxes.

Designated Party: _____ Relationship to patient: _____

Designated Party: _____ Relationship to patient: _____

Designated Party: _____ Relationship to patient: _____

Designated Party: _____ Relationship to patient: _____

I understand that this authorization is voluntary and that once any information is released to the person(s) named above, the released information may no longer be protected by federal privacy regulations. I understand that this authorization will be effective for the lifetime of the patient unless this office is notified in writing; however, if I do revoke the authorization, it will not have any effect on any actions taken by Pflugerville Vision Care *prior* to their receipt of the revocation.

_____ _____

Signature or patient or patient's representative **Date**

Printed Name of Patient's Representative: _____