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:

Blurred vision	No	Yes: Do you wear glasses? No Yes: Full time____ Reading ____ Distance only____ Do you wear contacts? No Yes: Soft ____ Hard____ Hybrid____ Brand: _____ ***If you don't wear contacts, would you like try them? Yes No***
Flashes of light	No	Yes
Floaters	No	Yes
Itchy Eyes	No	Yes
Dry Eyes	No	Yes
Eye turn (strabismus)	No	Yes
Eye Surgery	No	Yes: Type: _____ When: _____
Eye Injury	No	Yes: Type: _____ When: _____
Cataracts	No	Yes Removed? No Yes—When? _____
Glaucoma	No	Yes: Treatment: _____
Retinal disorders	No	Yes: Type: _____ Treatment: _____
Keratoconus	No	Yes: Treatment(s) Tried: _____

Amblyopia (one eye is not correctable to 20/20 vision): No Yes: Which eye? _____

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 if known:

Are you allergic to any medications?

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_____

Patient Name: _____ Date of birth: _____

Patient Payment Agreement:
I authorize the release of any medical or other information necessary to process insurance claims, payment of government benefits to either the patient or Pflugerville Vision Care, and payment of medical benefits to the physician. I have no other insurances (vision and medical) than the ones disclosed to PVC. 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.

Acknowledgement of 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 which is located in its entirety on the website at www.pflugervillevisioncare.com as well as at the front desk. I agree to accept the policies of this office and continue my care with Pflugerville Vision Care.

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, and have access to my medical record as it pertains to Pflugerville Vision Care.

Designated Person(s): _____

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 Person(s): _____

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.

I understand that my signature below is for all statements above.

If you are signing as a personal representative of the patient, please indicate your relationship. By signing for a minor, you attest that you have **legal authority** to make medical decisions for the minor.

_____ _____
Signature of patient or patient's *legal* representative **Date**

Printed name of patient's representative: _____

Relationship to patient: _____