

WELCOME TO OUR OFFICE

Name _____ M _____
Last First MI F Nickname Date of Birth Social Security #

Street Address Home Phone # Work Phone # Cell Phone #

City State Zip Employer/School Spouse/Parent's name Spouse's Employer

What are the names and ages of your children still living at home? _____

Do you prefer to be contacted: At Home At Work By Cell

E-Mail Address: _____

Who may we thank for referring you to our office? _____
Name of Friend or Relative

If not referred, how did you choose our office for your needs? Saw sign/Building Insurance List Newspaper Radio
 Another Dr. Yellow Pages: Which Directory? _____ Web Site? _____ Other? _____

INSURANCE INFORMATION:

Vision Insurance _____ Primary Medical Insurance _____

Subscriber Name _____ Subscriber Name _____

Subscriber ID# _____ Subscriber ID# _____

Subscriber Birth Date _____ Subscriber Birth Date _____

Do you participate in a flex spending account? Yes No

How will you settle your account today? Cash Check Credit Card Debit Card

Monthly interest charges of one and a half percent (1 1/2%) per month or eighteen percent (18%) per year will accrue thirty (30) days after billing. The undersigned shall assume the responsibility for a ten percent (10%) collection agency fee if referred to a collection agency, attorney fees, court costs, and other costs incurred in an attempt to collect payment. All returned checks will be charged a \$30 fee.

We are required by law to maintain the privacy of, and provide individuals with, our HIPAA Notice of Privacy Practices which outlines our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices. _____ (Please initial)

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I authorize payment of these benefits directly to Mooresville Family Eye Care, P.C. on my behalf for any services and materials furnished. I authorize any holder of medical information about me to release to the Health Care Financing Administration or my Insurance Company and its agents any information needed to determine these benefits payable to related services.

Lifetime Patient Signature: _____ Date: _____

Patient Medical History

Name (Last, First, Middle): _____ DOB: _____

Address: _____

Preferred Name: _____ SS No: _____ Home Phone _____

Work Phone _____ Cell Phone _____ E-mail Address _____

Have you ever been diagnosed or treated for the following?

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Breathing Problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Cholesterol | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Nerves/Depression | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Skin/Immune Disease |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Lazy Eye | <input type="checkbox"/> Eye Infection | <input type="checkbox"/> Eye Injury |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Iritis/Uveitis | <input type="checkbox"/> Corneal Abrasion | <input type="checkbox"/> Macular Degeneration |
| <input type="checkbox"/> Retinal Detachment | <input type="checkbox"/> Other Eye Disorders | <input type="checkbox"/> Other _____ | |

Name of Family Physician _____ Phone # _____

Do you...(Check all that apply)

- ...Prefer not to wear your glasses at times?
- ...Have interest in a "test drive" of the latest in Contact Lens design?
- ...Want information on Laser Vision Correction Surgery?
- ...Think you might benefit from thinner, lighter lenses?
- ...Have more than 1 pair of current Rx glasses?
- ...Have Prescription Sunglasses?
- ...Smoke?

Current Medications: Check if None : _____

Please List All Medications You Are Allergic To: _____

Is There a Family Medical History of Any of the Following? (Blood Relatives)

	Relationship		Relationship
Blindness	<input type="checkbox"/> _____	Corneal Problems	<input type="checkbox"/> _____
Cataracts	<input type="checkbox"/> _____	Macular Degeneration	<input type="checkbox"/> _____
Glaucoma	<input type="checkbox"/> _____	Retinal Problems	<input type="checkbox"/> _____
Lazy Eye	<input type="checkbox"/> _____	High Blood Pressure	<input type="checkbox"/> _____
Diabetes	<input type="checkbox"/> _____	Heart Disease	<input type="checkbox"/> _____

How many hours a day do you spend on the computer? _____ Do you have a pair of computer glasses? Yes No

How many hours a week do you spend outdoors? _____

Are you aware of the dangers of excess UV exposure? Yes No

What are your hobbies and interests? _____

The above information is true to the best of my knowledge.

Signature: _____ Date: _____

Responsible Party: _____ Phone: _____

Address if Different than Above: _____