Date:

HOOSIER EYE DOCTOR

PATIENT

Name:

Last First Mid. Initial

Patient Nickname:

Gender: M F

Date of Birth:

Social Security#:

Address:

City/State/Zip:

Home Phone:

Daytime Phone:

Cell Phone: Text OK? Y N

Email:

Communication pref.: Any Email Postal Phone Text

Marital Status: S M D W OTHER

Employment Status: full time part time not employed retired full time student part time student

Employer name:
(School for Students)

Occupation:
Grade if Student

Preferred Language: English
Other:

Race:		American Indian or Alaska Native,
		Asian
		Black or African American
		Native Hawaiian or other Pacific Islander
		White
		I prefer to not answer
Ethnicity:		Not Hispanic or Latino
		Hispanic or Latino
		I prefer to not answer

How did you hear about us?

Whom may we thank for referring you to us?

INSURANCE

Vision Insurance Name:

Health Insurance Name:

Please provide us with your insurance card(s)

PRIMARY INSURANCE POLICY HOLDER - skip if self

Name:
Last First MidInitial

Date of Birth:

Relationship to the Patient:

Social Security #:

Gender: M F

Home Phone:

Address:

Daytime Phone:

City/State/Zip:

Cell Phone:

Employer:

Email::

PERSON RESPONSIBLE - skip if self or insurance policy holder

Name:
Last First Mid. Initial

Gender: M F

Date of Birth:

Address:

Home Phone:

Daytime Phone:

City/ State/ Zip:

Cell Phone:

Emergency Contact

Name:

Phone:

Have we seen you before? Y____ N____ If Yes has it been within the last 3 years Y ____ N ____

When was your last eye examination? _____ What is your previous eye doctor's name?_____

When was your last visit to your physicians? _____ What is your physician's name? _____

Do you wear glasses? Y ____ N ____ Since when? _____

If yes how often? All the time ___ Occasionally ___ Driving ___ Reading only ____ Other _____

Do you have your Glasses today? Y ___ N ___ How old are they? _____

Do you wear contact lenses Y ___ N ___ If yes which type? Hard _____ Soft _____ Name _____

Do you have your contact lenses' on today? _____ How old are they? _____

What can we do for you today? Do you have a Specific Problem or Need?_____

PATIENT VISUAL SYMPTOMS: (CHECK THOSE YOU HAVE HAD)

Blurred vision: Y ___ N ___ If yes: **distance** ____ **near** ____ **both** ____ with or without Glasses or Contact Lenses or both _____

Discomfort or eye strain: Y ___ N ___ If yes: **distance** ____ **near** ____ **both**____ with or without Gl or C L or both_____

___Double vision
___ See flashing lights
___ Burning eyes
___ See floaters or spots

___ Twitching eyelid
___ Itching eyes
___ Dry eyes
___ Temporary loss of vision

___ Red Eyes
___ Watering eyes
___ Light sensitivity

___ Difficult to focus
___ Headaches
___Sudden vision changes
___ Other_____

Have you ever had any serious eye disease, injury or surgery? Y ___ N ___ Is yes, explain _____

Are you presently using any eye drops? Y ___ N ___ If yes, list _____

PATIENT HEALTH HISTORY: (CHECK THOSE YOU HAVE HAD)

___ High Blood Pressure
___ Diabetes
___ High Cholesterol
___ Allergies

___ Migraine headaches
___ Thyroid condition
___ Heart condition
___ Infectious disease

___ Glaucoma
___ Cataracts
___ Lazy Eye
___ Turned Eye

___ Blindness/Reduce Vision
___ Retinal Disease
___ Poor color vision
___ Other

Explain where necessary: _____
Do you smoke? Y ___ N ___ Do you consider your health: Good ___ Fair ___ Poor___

Are you presently taking any medications: Y ___ N ___ If yes, list _____

Are you allergic to any medications? Y ___ N ___ If yes, which? _____

Have you ever had any serious disease, injury or surgery? Y ___ N ___ If yes, explain _____

FAMILY HEALTH HISTORY: (CHECK THOSE SOMEONE IN YOUR FAMILY HAS HAD)

___ High Blood Pressure
___ Diabetes
___ Allergies

___ Heart condition
___ Thyroid Condition
___ Infectious Disease

___ Blindness
___ Glaucoma
___ Cataracts

___ Lazy Eye
___ Turned Eye
___ Poor Color Vision

___ Retinal Disease
___ Other _____

Additional Comments: _____

I authorize and consent to examination and treatment. I certify that the above information is correct.

PLEASE SIGN HERE _____ **DATE** _____

Hoosier Eye Doctor

Financial Policy

Payment is due in full at the time services are rendered and/or orders are placed, including insurance co-payments and any other amounts determined to be patient responsibility. All charges not paid by my insurance, including due to inactive policy status, are my responsibility and I will pay them promptly. Finance charges will accrue at 2% per month on any outstanding balance, from the date charges are incurred, with a 30 day grace period provided. Outstanding balances older than 120 days will be forwarded to a debt collection agency. All debt collections fees, court costs and attorney fees will be the patient's responsibility. All balances due on collection accounts must be paid in full before any future appointments can be scheduled and/or orders placed. Eyeglasses and Contact Lenses are prescription medical devices and are warrantied against manufacturer's defects at the time of dispensing, but are non-refundable. It is the patient's responsibility at the time of ordering Eyeglasses and Contact Lenses to know and understand their vision insurance benefits and to provide us with the correct insurance company, so that as a courtesy, we can successfully file a claim.

I understand the above policy.

Patient Signature or Patient's Representative Date

HIPAA Privacy

Acknowledgement of Receipt of Privacy Practices Notice

By signing this acknowledgement of Receipt of Privacy Practices Notice ("the Notice"), I acknowledge and agree that I have received a copy of the Notice for review and to keep for my records on the date identified below.

I understand that Hoosier Eye Doctor ("HED") may use and disclose necessary personal health information (for example: my name, address, subscriber identification number, eye exam information and/or type of products provided) to another party to permit HED to perform its administrative duties, provide me with eye care services and products, process my vision benefit claims and communicate with me regarding vision care services provided by HED (for example: mailings of exam reminders or information about services/products provided by HED).

I can be assured that HED will not sell my personal health information of any kind to a third party for such party's own use. The information includes the vision services and products that I have received from HED.

Patient Signature or Patient's Representative Date