PATIENT INFORMATION

Date:_____ Updated _____ Updated _____

Thank you for choosing our practice for your eyecare needs. Please complete this form in ink.
If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

LAST NAME			SEX □ MALE □ FEMALE
FIRST NAME	MI		DATE OF BIRTH
TITLE	SUFFIX		MARITAL STATUS
ADDRESS			EMP STATUS
CITY			EMPLOYER
STATE	ZIP		OCCUPATION
HOME PHONE			SS#
E-MAIL			WHO IS YOUR PRIMARY CARE PROVIDER? _____ WHAT CITY? _____

Insurance Information

INSURANCE NAME		**INSURED** LAST NAME	
INSURED ID		FIRST NAME	MI
PLAN NAME		ADDRESS	
POLICY GROUP		CITY	
RELATION TO INSURED		STATE	ZIP
HOME PHONE		DOB	SS#
EMPLOYER			

Responsible Party

Guarantor's Name (if not self) _____ SS# _____
Address _____ City _____ State ___ Zip _____
Primary Phone _____ Home/Work/Cell Secondary Phone _____ Home/Work/Cell
You or Your Guarantor's Employer _____
_____

Referrals

WERE YOU REFERRED BY A DOCTOR? IF YES WHO?
DR'S NAME _____
ADDRESS _____CITY _____ STATE _____

WHOM MAY WE THANK FOR YOUR REFERRAL?_____

How did you hear of our office? Word of mouth / Phone book / Internet / Drive by / Other

MAIN REASON FOR VISIT

_____

_____

PRESENT EYE ILLNESS (HPI)

ANY VISION LOSS? _____

DO YOU HAVE ANY EYE PROBLEMS? _____

MEDICAL HISTORY (ROS)

ANY MEDICAL CONDITIONS? _____

DIABETES YES / NO TYPE _____ DATE DIAGNOSED _____

MEDICATION ALLERGIES YES / NO WHICH ONES? PENICILLIN, SULFA, CODEINE (CIRCLE) OTHER_____

ARE YOU TAKING MEDICATIONS FOR ANYTHING? (INCLUDING GLAUCOMA DROPS, HORMONES, BIRTH CONTROL) YES NO
(IF SO, PLEASE LIST ON THE SEPARATE SHEET PROVIDED FOR MEDICATIONS)

FAMILY HISTORY (BLOOD RELATIVES)

DIABETES YES NO RELATION _____ MACULAR DEGENERATION YES NO RELATION _____
CATARACTS YES NO RELATION _____ HIGH BLOOD PRESSURE YES NO RELATION _____
GLAUCOMA YES NO RELATION _____ RETINAL DETACHMENT YES NO RELATION _____
OTHER EYE CONDITIONS YES NO DESCRIBE _____ RELATION _____

PERSONAL EYE INFORMATION

HAVE YOU EVER HAD CATARACT SURGERY? YES NO IF SO, WHEN? RIGHT EYE _____ LEFT EYE _____

HAVE YOU HAD ANY OTHER EYE OPERATIONS? YES NO IF SO, DESCRIBE _____ DATE_____

HAVE YOU HAD ANY EYE INJURIES? YES NO IF SO, DESCRIBE _____DATE_____

HAVE YOU HAD ANY EYE DISEASE? YES NO IF SO, DESCRIBE _____ DATE_____

DO YOU HAVE ? GLAUCOMA YES NO IF SO, WHEN? RIGHT EYE _____ LEFT EYE _____

PERSONAL HEALTH HISTORY

WHAT IS YOUR GENERAL HEALTH? _____

DO YOU HAVE PROBLEMS WITH ANY OF THESE SYSTEMS? **(PLEASE CIRCLE YES OR NO ON EACH AND EXPLAIN BELOW IF ANSWERED YES)**

NON-MEDICAL ALLERGIES	YES NO	**ENDOCRINE** (DIABETES, THYROID)	YES NO
CARDIOVASCULAR (HEART DISEASE, HIGH BP)	YES NO	**GASTROINTESTINAL** (STOMACH, INTESTINAL)	YES NO
CONSTITUTIONAL (FEVER, WEIGHT LOSS)	YES NO	**GENITOURINARY** (KIDNEY, BLADDER)	YES NO
EAR, NOSE, THROAT	YES NO	**HEMATO-LYMPHATIC** (BLEEDING, ANEMIA)	YES NO
IMMUNOLOGIC	YES NO	**INTEGUMENTARY** (SKIN)	YES NO
MUSCULOSKELETAL (MUSCLE, JOINT PAIN, RHEUM ARTH)	YES NO	**NEUROLOGICAL** (HEADACHE, SEIZURES)	YES NO
RESPIRATORY (LUNG, BREATHING, COUGH)	YES NO	**PSYCHIATRIC** (MOOD, DEPRESSION)	YES NO

IF CIRCLED YES, PLEASE EXPLAIN _____

_____

Social History

Federal Law mandates we ask these questions.

What is your height? _____ What is your weight? _____

Do you use tobacco products? □ No □ Yes If yes, what type? _____ light / moderate / heavy

Do you use alcohol products? □ No □ Yes If yes, what type? _____ light / moderate / heavy

Do you use illegal drugs? □ No □ Yes If yes, what type? _____ light / moderate / heavy

Sexually Transmitted Disease □ None □ Yes HIV Positive □ No □ Yes

Financial Policies

We accept: Cash, Personal Check, Major Credit Cards and CareCredit.

Ask about 12 months zero interest financing

We participate in many insurance plans. **We make both vision and major medical claims in your behalf.**

Please show all insurance coverage. We will work hard to find your coverage and lower your out-of-pocket.

Every reasonable effort is made to compute your bill or share of the bill at the time of your visit. Your part is expected at the time of service. If the insurance company instructs us to bill an additional amount, we may, after we hear from them. We welcome questions about your billing.

All of our billing practices are based on good business ethics. We pledge to answer all billing inquiries within a reasonable time.

Privacy Policies

Our privacy policy is posted prominently in our waiting area. A copy is ready for you to take home. We do not share your information with anyone except: other healthcare professionals, your insurance company and those persons you name. Please list those persons here.

1. Your spouse and family members □ No □ Yes
2. _____
3. _____
4. _____

AUTHORIZATION

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize Dr. Nelson to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such eyecare to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to Dr. Nelson. I understand that my insurance carrier may pay less than the actual bill for services.

I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____

SIGNATURE OF PATIENT (Or parent if a minor) DATE _____

I acknowledge that I have received a copy of Dr. Nelson's Notice of Privacy. Updated 9/1/13

X_____

SIGNATURE OF PATIENT (Or parent of a minor) DATE _____

Interest

Would you like information on LASER vision correction? □ Yes □ No
Would you like information on thin lenses? □ Yes □ No
Would you like information on our current promotions? □ Yes □ No
Would you like information on contact lenses? □ Yes □ No

Reviewed by Doctor Date _____ Date _____ Date _____

Date _____ Date _____ Date_____ Date _____