Welcome To Our Practice

Name_____Male/Female_____

Street Address(Home)_____

City_____State_____ Zip Code_____

Home Phone#_____WorkPhone#_____Cell #_____

EmailAddress_____Marital Status_____

Birth Date_____ Referred By_____

Reason for Visit_____

Employer_____ Occupation_____

Employer's Address_____

Primary Physician's Name_____Phone#_____

Last Eye Exam and Doctor_____

Financial Responsibility (if different from patient)

Name_____Relationship to Patient_____

DOB_____SS#_____Employer_____

Street Address_____City_____State_____

Please Circle(This information is requested due to Healthcare Reform Laws)

Race: Am. Indian Asian Black Native Hawaiian White Multi-Racial

Ethnicity: Hispanic/Latino Non-Hispanic/Non-Latino

Preferred Language: English Spanish Other_____

Communication Preference: Email Postal Telephone

Insurance Information(*Please provide copies of all insurance cards)*

Employer Name_____ Member ID_____

Vision Insurance_____ Group#_____Ins. Phone#_____

Medical Insurance_____ Group#_____Ins Phone#_____

Secondary Insurance_____ Group#_____Ins.Phone#_____

Policy Holder's Name_____DOB_____SS#_____

___If it is necessary to discuss your health information with someone other than yourself, please list the name/s and phone numbers of the person/s we should contact. If no one is listed under federal regulations we are prohibited from speaking with anyone else concerning your care.

Person to Contact_____Relationship_____Phone#_____

Person to Contact_____Relationship_____Phone#_____

Authorizations

-I hereby authorize Phifer Eye to bill any and all of my insurance providers for services rendered to me by Phifer Eye. I authorize the release of any of my personal health information so that benefits may be paid directly to Phifer Eye.

-I authorize Phifer Eye to access and process my prescription and medicine information electronically.

-I acknowledge that I have received the Phifer Eye Notice of Privacy.

-I acknowledge that I am financially responsible for any and all charges related to my visit. It is my responsibility to resolve any and all outstanding balances or issues with the insurance company.

-I acknowledge that any copay is due on the date of service.

-I acknowledge that this authorization will remain in effect from the date of my signature below unless I change it.

-I acknowledge that I am entitled to a printed summary of my eye exam.

Patient's Signature_____Date_____

Medical History

*Are you currently being treated for any of the following? Please **circle** all that apply.*

Acid Reflux	**AIDS**	**Allergies**
Alzheimer's	**Anxiety**	**Arthritis**
Asthma	**Bladder**	**Cancer**
COPD	**Crohn's Disease**	**Depression**
Diabetes	**Cholesterol**	**Emphysema**
Fibromyalgia	**Gout**	**Heart Disease**
Herpes Simplex	**High Blood Pressure**	**Kidney Disorder**
Leukemia	**Lung Disease**	**Lymphoma**
Melanoma	**Meniere's Disease**	**Multiple Sclerosis**
Osteoporosis	**Prostate Disorder**	**Psychiatric Disorder**
Seizures	**Sleeping Disorder**	**Stroke**

Thyroid Disease **Other**_____

Please list all medications that you are currently taking _____

Please list all drug allergies_____

Please list all major surgeries_____

Please list any significant family medical problems_____

EYE HISTORY

Have you ever had eye surgery? Please list

_____

Are you currently taking any eye medications? Please list _____

***Have you ever had any of the following? Please circle all that apply*.**

Cataracts	**Crossed Eyes**	**Diabetic Retinopathy**
Dry Eyes	**Fuch's Dystrophy**	**Glaucoma**
Herpes Keratitis	**Iritis**	**Keratoconus**
Macular Degeneration	**Papilledema**	**Retinal Detachment**

Other_____

Do you have a family history of eye problems/disease?_____

_____