Date / /

Name: _____ Date of Birth: _____ Age: _____

Address: _____ Email Address: _____

City/State: _____ Zip: _____ Home Phone: _____ Cell Phone: _____

SSN: _____ Work Phone: _____

Sex: M F Marital Status: _____ (Please circle the best contact number)

Employer: _____ Occupation: _____

Primary care physician: _____ Last medical exam: _____ Hobbies: _____

Emergency contact: _____ Relationship: _____ Best Contact Phone: _____

How did you hear about us? (Please circle)

Friend/Family Who?_____ Yellow pages TV/Newspaper Website Another Doctor Insurance Plan Previous patient

Insured's Name: _____ Insured's Employer: _____

Insured's Work phone: _____ Insured's SSN: _____ Insured's Date of Birth: _____

Consent for Use or Disclosure of Patient Information for the Purposes of Treatment, Payment and Healthcare Operations

I hereby consent to Premier Family EyeCare ("the Practice") using or disclosing my protected health information for the purpose of providing treatment to me, obtaining payment for health care services rendered to me or to carry out the Practice's health care operations. I also consent to the Practice using or disclosing my protected health information for treatment activities provided by another health care provider, as well as the payment activities conducted by another health care provider or entity. I further consent to the disclosure of my protected health information in order for another provider or health care entity to conduct health care operations including quality assessment and reviewing the competence of health care professionals.

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge the Practice has provided me a copy of its Notice of Privacy practices, which provides a detailed description of the uses and disclosures allowed by this consent, as well as other rights I have regarding my protected health information.

Consent for Treatment

I certify that it is my legal authority to grant consent for medical services rendered to the patient named herein. I consent to medical treatment by the Practice including instillation of diagnostic eye drops that may blur my vision. I understand that there are additional charges for prescriptions and contact lens fitting which are not included in the fee for the eye examination and are my responsibility. For safety reasons, a contact lens prescription can not be written with out a fitting.

Financial Policy

We are dedicated to providing you with the best possible care and service, and regard your understanding of our financial policies as an essential element of your care and treatment. If you have questions, feel free to discuss then with our staff.

Payment: Unless other arrangements have been made in advance by either yourself or your health coverage carrier, full payment is due at the time of service. For your convenience, we accept cash, check, money order, VISA, MasterCard, Discover and Care Credit.

Insurance: We participate with most major insurance companies. We will bill those plans with which we have an agreement. The co-payment will be collected prior to your departure and after being examined by the doctor. In the event your insurance plan determines a service to be "not covered," you will be responsible for the complete charge. We will bill you for the charge and payment is due upon receipt of statement. You can request an itemized statement to file yourself for reimbursement. When a medical diagnosis is present (high blood pressure, diabetes, eye infections, dry eyes, allergies, cataracts, etc) it is necessary to file the claim with your major medical carrier and collect their predetermined co-pay amount. Vision insurance does not cover medical eye problems, just as medical insurance does not cover routine vision problems. These rules are defined by the insurance carriers themselves, not our office. There is no way to know prior to the exam which type of insurance will apply or with whom our office will file the claim.

Minor Patients: The adult accompanying a minor patient is responsible for payment for all services rendered.

Non-insured Patients: If you have no insurance coverage, we will work with you to obtain a suitable payment plan. Your initial office visit will need to be paid in full, unless other arrangements have been made in advance.

I have read and understand the consent and financial policies of PFE as detailed above and agree to be bound by these terms

_____ _____ _____

(Signature of Patient or Personal Representative) (Date) (Printed name)

_____

(Description of Personal Representatives Authority)

06/01/12 PFE

Medical History

List all major Surgeries or hospitalizations you have had:

_____

Are you pregnant or nursing? Have you had a Flu Vaccine this Year?

Do you Currently, or have you ever had any significant problems with **(Please circle all that apply):**

Dry Eyes **Cataracts** **Retinal Disease** **Glaucoma** **Eye Infections**

Eye Injury **Lazy Eye** **Crossed Eye** **Macular Degeneration**

Eyecare Needs: (Please Circle Yes or No)

Do you need new eyeglasses or contact lenses?	Y / N
Do you have more than one pair of eyeglasses?	Y / N
Do you work on a computer?	Y / N
Do you experience problems with glare/reflections?	Y / N
Are you sensitive to sunlight?	Y / N
Are you happy with vision/comfort of your contacts?	Y / N
Are you bothered by restrictions with your bifocals?	Y / N
Are there times you would rather not wear glasses?	Y / N
Would you benefit from thinner, lighter lenses?	Y / N
Do you spend a lot of time outdoors?	Y / N
Do you have any visual difficulty when driving?	Y / N

Do You Experience: (Please circle one number)

0=Never 1=Sometimes 2=Often 3=Constant

Dryness, Grittiness or Scratchiness?	0	1	2	3
Soreness or Irritation?	0	1	2	3
Burning or Watering?	0	1	2	3
Eye Fatigue?	0	1	2	3

0=No Problems 1=Tolerable 2=Uncomfortable 3=Bothersome 4=Intolerable

Dryness, Grittiness or Scratchiness?	0	1	2	3	4
Soreness or Irritation?	0	1	2	3	4
Burning or Watering?	0	1	2	3	4
Eye Fatigue?	0	1	2	3	4

Social History

Do you use tobacco products or illegal drugs? Type/Amount/How Long? _____

Have you ever been exposed to or infected with Gonorrhea, Hepatitis, HIV, or Syphilis? _____

Family History

Note any Family History (Mother, Father, Sister, Brother, or Children)

Disease/Condition	Relationship	Disease/Condition	Relationship
Blindness-		Cancer-	
Cataracts-		Diabetes-	
Crossed/Lazy Eye-		Heart Disease-	
Glaucoma-		High Blood Pressure-	
Macular Degeneration-		Kidney Disease-	
Retinal Disease-		Thyroid Disease-	
Arthritis-		Lupus-	
OTHER-_____			

Review of Symptoms: Do you currently, or have you ever had any significant problems with (Circle ALL that Apply)

Constitutional
Fever
Weight Loss/Gain

Integumentary(Skin)
Skin Lesions
Rosacea

Neurological
Headaches
Migraine
Seizure
Stroke

Psychiatric
Depression/Anxiety
Anxiety

Endocrine
Diabetes
Thyroid
other glands

Ear, Nose, Mouth, Throat
Allergies
Sinus Congestion
Chronic Cough
Dry Mouth

Respiratory
Asthma
Bronchitis
Emphysema

Cardiovascular
Heart Disease
High Blood Pressure
Vascular Disease
High Cholesterol

Gastrointestinal
Ulcer
Reflux
Diarrhea/Constipation

Genitourinary
Genitals
Kidney Disease
Kidney Infections
Bladder infections

Bones/Joints/Muscles
Rheumatoid Arthritis
Muscle Pain
Joint Pain

Lymphatic/Hematologic
Anemia
Bleeding Problems

Allergic/Immunologic
Seasonal Allergy
Medication Allergy

Any Other Conditions not listed above _____

List Medications:

List Medication Allergies: