## CONTACT INFORMATION

Full Name_______________________________
Street Address____________________________
City_________ State_________Zip Code______
Primary Phone Number____________________
May we contact you via text message? ◯Yes ◯No
Email Address____________________________

Emergency Contact: Name_________________
Relationship____________Phone____________

## PERSONAL INFORMATION

Date of Birth_____________________________
Gender: ◯ Male ◯ Female
Marital Status: ◯ Married ◯ Single
Social Security Number____________________

How did you hear about our office?

_______________________________________

Occupation_______________________________
Employer________________________________
Hobbies/Interests_________________________

## INSURANCE INFOROMATION

Primary Vision Insurance Company______________________________________________
Policy ID#__________________________________ Group#__________________________________
Policy Holder's Name__________________________ Policy Holder's Birth Date____________________
Policy Holder's Employer_______________________ Policy Holder's Social Security#_______________

Primary Medical Insurance Company_____________________________________________
Policy ID#__________________________________ Group#__________________________________
Policy Holder's Name__________________________ Policy Holder's Birth Date____________________
Policy Holder's Employer_______________________ Policy Holder's Social Security#_______________

## FINANCIAL POLICY

Please initial each box below signifying you have read and agree to the financial policy

☐ I understand that I am responsible for fees, co-payments, deductibles and associated charges related to my exam, the day of my appointment.

☐ I understand that I cannot receive contact lenses and/or glasses until they are paid for in full. Materials may be ordered after collecting 50% of the fee, with the remaining balance due upon receiving materials.

☐ I understand that I am responsible for payment of any remaining charges after my insurance has been billed.

## PRIVACY STATEMENT

Please initial each box below signifying you have read and agree to the following statements

☐ I authorize Advanced EyeCare of Blackfoot to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child to third party payers and/or health practitioners.

☐ I acknowledge that I was offered a copy of Advanced EyeCare of Blackfoot’s HIPPA policy.

☐ I authorize and request my insurance company to pay directly to Advanced EyeCare of Blackfoot benefits payable.

______________________________________ ______________________________

Signature of Patient/Responsible Party Date

## OCULAR HISTORY

Reason for today's visit:____________________________________________________________

Last Eye Exam______________________________ Location:________________________________

Primary Vision Correction: ◯Glasses ◯Contacts ◯Lasik ◯None

Age of current glasses:______________ Do you wear contacts?______ What type? __________________

Previous eye injury/surgery_______________________________________________________________

Do you or any blood relatives have any of the following eye conditions?

| | Self | Relative | Relationship: |
|---|---|---|---|
| Glaucoma | ◯ | ◯ | ____________________ |
| Macular Degeneration | ◯ | ◯ | ____________________ |
| Retinal Detachment | ◯ | ◯ | ____________________ |
| Flashes/Floaters | ◯ | ◯ | ____________________ |
| Dry Eyes | ◯ | ◯ | ____________________ |

Other:_________________________________________________________________________________

Additional Eye Concerns:_________________________________________________________________

## Medical HISTORY

What is your general health:_____________________ Last Doctor Visit:___________________________

Name of family doctor:____________________________ Preferred Pharmacy:_______________________

Current Medications:________________ ________________ ________________ ________________

Allergies:_______ ________________ ________________ ________________ ________________

Do you or any blood relatives have any of the following conditions?

| | Self | Relative | Relationship: |
|---|---|---|---|
| Diabetes | ◯ | ◯ | ____________________ |
| High Blood Pressure | ◯ | ◯ | ____________________ |
| Thyroid Disease | ◯ | ◯ | ____________________ |
| Heart Disease | ◯ | ◯ | ____________________ |
| Autoimmune Disease (specify) | ◯ | ◯ | ____________________ |
| Cancer (specify) | ◯ | ◯ | ____________________ |

Other:_________________________________________________________________________________

Diabetes: Type:_____Year of Diagnosis:_________Blood Sugar Range:___________Last A1C:_________