PATIENT INFORMATION (PLEASE FILL IN ALL INFORMATION OR MARK N/A - Use Black Ink)

First Name _____ Middle Initial ____ Last Name _____

Street_____ City_____ State_____ Zip_____

Date of Birth _____ Sex M / F Social Security # _____ Marital Status: S M D W

Phone #'s: Home_____-_____-_____ Work/ Daytime_____-_____-_____ Cell _____-_____-_____

PLEASE INDICATE YOUR PREFERRED COMMUNICATION FOR REMINDERS & EYEWEAR NOTIFICATIONS (Circle)

Voice Message via Home Phone (Voice Msg Must be a LANDLINE) **Text via Cell Phone** **Email**

Email Address _____ Race _____ Ethnicity: Non-Hispanic/Hispanic Latino/Other

Employer/ School _____ Occupation/Teacher _____

Employment Status: Full Time Part Time Retired Student **REASON FOR VISIT** _____

Names of family members in household _____

Were you referred by another Doctor / Patient? If so,name please _____

INSURANCE INFORMATION

VISION Coverage *YES / NO Insurance Co. Name: (If no, pls initial)*_____

Policy Holder's Name _____ Relationship to Patient _____

Policy Holder Date of Birth _____ Social Sec # _____ Phone # _____

Policy Holder Address (if different from above) _____ Employer _____

MEDICAL Coverage *YES / NO Insurance Co. Name* _____

Policy Holder's Name _____ Relationship to Patient _____

Policy Holder Date of Birth _____ Social Sec # _____ Phone # _____

Policy Holder Address (if different from above) _____ Employer _____

Does your medical insurance require a referral YES NO

BILLING INFORMATION (after insurance)

Send bills to: Name_____ Relationship to patient_____

Address_____

SIGNATURE ON FILE – Please Read Carefully

I authorize the use of this form on all my insurance submissions. I authorize the release of information to all my insurance companies. I understand that I am responsible for my bill. ***I understand I am responsible for any referrals required by my insurance****. I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies. I authorize payment directly to my doctor.* ***INSURANCE COPAYS ARE DUE AT THE TIMEOF SERVICE.*** *OPTOS Retinal Scans are an optional test recommended for retinal health and analysis. This test is typically* ***NOT*** *covered by insurance.* ***Medicare Patients****: In addition to the above statement, I understand Medina Vision Centre has agreed to accept the charge determination for Medicare-assigned cases as the full charge and I as the patient am only responsible for the deductible, co-insurance and non-covered services. I hereby state that the above information I have provided is correct to the best of my knowledge.*

I have been provided with and understand the Financial Policy and Managed Care Statement effective 6/20/2013

_____ _____

Signature of Patient or Responsible Party Date

CONTINUED ON BACK, PLEASE TURN OVER →

OCULAR & MEDICAL HISTORY

Have you ever had any of the following? (Please check all that apply)

___ Corneal Problems
___ Cataracts
___ Retinal Problems
___ Glaucoma
___ Amblyopia (Lazy Eye)
___ Double Vision/Strabismus Problems
___ Dry Eye
___ Injuries/Trauma to Eyes

Do you currently wear contacts? Yes No If yes, what type? Soft Gas Permeable CRT

Have you had Lasik or PRK Surgery? Yes No If yes, when _____

Do you currently have or previously had any of the following conditions? (Please check all that apply)

___ Diabetes Last A1-C# _____
___ Lupus
___ Rheumatoid Arthritis
___ HIV/AIDS
___ Hepatitis
___ Heart problems
___ Hypertension
___ Asthma (Current / Previous)
___ Cancer (Current / Previous)
___ History of Stroke
___ Kidney / Liver problems
___ Thyroid problems
___ Currently Pregnant / Breastfeeding
___ Tobacco Use _____ (Cigarette / Chew)
___ Consume Alcohol? _____ drinks per wk/day
___ Any Medical Condition Not Listed Above*

* _____

Current Height_____ **Current Weight** _____ **(Required by most insurance companies. Thank You!)**

Please list any Medical or Environmental Allergies DO NOT LEAVE BLANK, PUT "***NONE***" IF NONE

_____

_____

Please list your medications and dosage DO NOT LEAVE BLANK, PUT "***NONE***" IF NONE

_____

_____

Primary Care Physician/Specialist _____

Address & Phone # _____

Pharmacy Name & Location _____

FAMILY HISTORY

Does anyone in your family have any of the following conditions? (Check all that apply)

___ Glaucoma ___ Cataracts ___ Keratoconus ___ Retinal problems/Macular Degeneration