



EYE CENTER of Ephraim

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New Patient Information. (please print)

Name _____
Mailing Address _____
City _____ Zip Code _____
Home Phone _____ Cell Phone _____
Date of Birth _____ Age _____
Email _____
Preferred Language: English Spanish
Communication Preference: Email Postal Telephone

Occupation _____ full-time part-time
Employer _____
Employer Phone _____
Social Security Number _____
 Male Female
 Single Married Divorced Widowed
Race _____
Ethnicity: Hispanic or Latino Not Hispanic or Latino
Spouse's Name _____ Date of Birth _____
Spouse's Social Security Number _____

If you are a student or under 18 years of age, please complete this section.

Name of Father _____
Father's Date of Birth _____
Address _____
Father's Social Security Number _____
Father's Occupation _____ full-time part-time
Father's Employer _____
Employer's Address _____
Work Phone _____

Name of Mother _____
Mother's Date of Birth _____
Address _____
Mother's Social Security Number _____
Mother's Occupation _____ full-time part-time
Mother's Employer _____
Employer's Address _____
Work Phone _____

Insurance Information

Primary Insurance _____
Address _____
Policyholder Name _____
Date of Birth _____ ID# _____ Group# _____

Secondary Insurance _____
Address _____
Policyholder Name _____
Date of Birth _____ ID# _____ Group# _____

Self Pay Information

Are you personally responsible for payment? Yes No Who is? _____ Relationship _____

Emergency Information (Who to notify - nearest relative or friend)

Name _____ Relationship _____
Home Phone _____ Work Phone _____ Cell Phone _____

Those we may talk to about your eye conditions

Name(s) _____
(Family, friends, etc. or write "none" if you don't want information discussed with anyone.)

CONSENT FOR TREATMENT/RELEASE

I hereby authorize the Eye Center of Ephraim to administer such medication and to perform such optical procedures as may be necessary for proper optometric care. I authorize the Eye Center of Ephraim to release my medical information to other medical professionals if a referral is needed for the continuation of my care. I authorize the release my prescription to optical labs and other suppliers, given that my prescription is current and not out dated.

FINANCIAL ASSIGNMENT AND AGREEMENT

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance. In order to control your cost of billings, we request that your charges for office visits be paid at the conclusion of each visit unless you are covered by Medicare.

I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished me. I authorize any holder of medical information about me to be released to the Health Care Financing Administration, its agents, or any insurance carrier(s) I may have, any information needed to determine these benefits or the benefits payable for related services.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment. I also understand that I will pay all balances due to the Eye Center of Ephraim in a timely manner. I agree to pay 1.5% interest on all past amounts of 30 days or more, not to exceed 18% annually. I agree to pay for all fees resulting from any action taken by, but not limited to, a collection agency and/or attorneys, court fees, filing, and service fees, not to exceed 50% of the principal balance including interest.

Signature of Patient (or parent if patient is a minor)

Date

10/06/11

Medical History Questionnaire

Name: _____ Today's Date: ____ / ____ / ____

Address: _____ Phone: _____

City: _____ Zip: _____ Work Phone: _____

Guardian (If Applicable): _____ Occupation: _____

Birth Date: ____ / ____ / ____ Social Security #: ____ / ____ / ____ Last Eye Exam: ____ / ____ / ____

Name of Medical Doctor: _____ Dr.'s Phone: _____

Last Medical Exam: ____ / ____ / ____

Medical History

Do you have any allergies to medications? no yes If yes, explain: _____

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies):

List all major injuries, surgeries and/or hospitalizations you have had: _____

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury: _____

Are you pregnant and/or nursing? no yes

Do you wear glasses? no yes If yes, how old is your present pair of lenses? _____

Do you wear contact lenses? no yes If yes, how old is your present pair of lenses? _____

Type of contact lenses: Rigid Soft Extended Wear Other Are they comfortable? yes no

Family History

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

DISEASE/CONDITION	NO	YES	?	RELATIONSHIP TO YOU
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

** Please turn this form over and complete side two **

