carteret VISION center

Thank you for supplying us with the following information. If you are a returning patient, we apologize for the added paperwork but new government regulations require us to get additional information that we may not have obtained in the past.

If you are a new patient—**Welcome!**—we are pleased you have chosen our office for your eye care needs!

Today's Date: _____

Personal Information

Patient's Full Name: _____ Date of Birth: ____/____/____

Preferred name (if different from above): _____ Gender: M F

Social Security #: _____ Marital Status: _____

Preferred Language: _____ Race/Ethnicity: _____

Mailing Address: _____

Home Phone: ( ) _____ - _____ Cell Phone: ( ) _____ - _____

E-mail Address: _____

Do you have Medical Insurance? : Y N

If yes, what company? : _____ Member ID: _____

Do you have Vision Insurance? : Y N

If yes, what company? : _____ Member ID: _____

Employment Information

Name of Employer (if minor, parent): _____

Address: _____

(Street) (City) (State) (Zip)

Telephone: ( ) _____ - _____ Job Title: _____

Referring Information

How did you hear about us? :

_____

Eye Care Information

When was your last eye exam? : _____

Do you wear glasses or contacts now? : Y N Glasses: ☐ Contacts: ☐

Any specific problems or concerns with your eyes or vision? (Please explain below):

_____

_____

_____

_____

Eye Surgery History

Date of Surgery: _____ /_____ /_____ Name of Surgeon: _____

Which Eye: Right Eye ☐ Left Eye ☐ Both Eyes ☐

Condition/Reason for Surgery: _____

Health Information

Height: _____ Weight: _____ Allergies: _____

Primary Care Doctor: _____ Telephone: ( ) _____ - _____

Tobacco Use

- ☐ Current every day smoker
- ☐ Current "some days" smoker
- ☐ Smoker
- ☐ Former smoker
- ☐ Never smoked

Alcohol Use

- ☐ Current every day drinker
- ☐ Current "some days" drinker
- ☐ Social drinker
- ☐ Former drinker
- ☐ Never drink

Family History

Please check below if you or your immediate family have or had any of the following health issues.

	Self	Mom	Dad	Siblings	Children
High Blood Pressure:	☐	☐	☐	☐	☐
High Cholesterol:	☐	☐	☐	☐	☐
Thyroid Disease:	☐	☐	☐	☐	☐
Diabetes:	☐	☐	☐	☐	☐
Glaucoma:	☐	☐	☐	☐	☐
Cataracts:	☐	☐	☐	☐	☐
Macular Degeneration:	☐	☐	☐	☐	☐

List of Current Medications

If you have a pre-made list, please see the girls up front so they can make a copy of it!

Acknowledgement

Assignment and release: I hereby authorize my insurance to be paid directly to Carteret Vision Center. I accept financial responsibility for non-covered services. I also authorize Carteret Vision Center to release any information required by my insurance company(s).

Signature: _____ Date: _____

Notice of Privacy Practices aka HIPAA

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me with payment of my insurance and/or Medicare benefits, and I authorize payment of these benefits directly to the Optometrists of Carteret Vision Center, on my behalf for any services and materials furnished.

I authorize this office to release any information needed to determine these benefits payable. If I have other health insurance coverage (as indicated on the HCFA-1500 claim form or electronically submitted claim), my signature authorizes release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as my agent, as above.

I also acknowledge that a copy of the HIPAA Privacy and Security Rules have been made available to me.

Signature: _____ Date: _____