PRIME EYE CENTER

WELCOME TO OUR OFFICE

________________ ________________ ________________ Gender: ☐ Male ☐ Female
Last Name First Name Middle Name

Date of Birth: ____/____/____ ____ ________ ________ ________
MM / DD / YY Age Ethnicity Occupation Last 4 SSN# (if needed for ins)

Street Address Apt. # City State Zip Code

Home/Mobile Phone Business Phone Email Address

GENERAL EYE HISTORY *(Check all that apply)*

	Self	Family
Blurred vision at distance	☐	
Blurred vision at near	☐	
Itchy eyes	☐	
Dry eyes	☐	
Double vision	☐	
Eye Turn (strabismus) or Lazy eye	☐	
Eye injury __________	☐	
Eye surgery __________	☐	
Flashes	☐	
Floaters	☐	
Glaucoma	☐	☐
Macular Degeneration	☐	☐
Other __________		

Date of last eye exam: ____________

What was the outcome of the exam: ☐ Glasses ☐ Contacts
☐ No prescription needed ☐ Other ________

Contact Lens History

☐ I would like to know my contact lens options
☐ I am not interested in contact lenses.

GENERAL HEALTH HISTORY *(Check all that apply)*

	Self	Family
Headaches	☐	
High blood pressure	☐	☐
Cardiovascular disease	☐	☐
Diabetes Type ____	☐	☐
Lung disease	☐	
Thyroid disease	☐	
Cancer ________	☐	☐
Arthritis (Rheumatoid)	☐	
HIV+	☐	
Seasonal allergies	☐	
Other condition(s)	__________	
Drug allergies	__________	

Are you pregnant or nursing? ☐ Yes ☐ No
Have you ever abused drugs or alcohol? ☐ Yes ☐ No
Do you smoke? ☐ Yes ☐ No

Please list ALL medications ____________

REASON FOR TODAY'S VISIT (check one)

☐ Regular check-up ☐ Office visit/Eye or Vision problem(s)____________

Medical Insurance Name ____________ **ID #** ____________

Name of primary card-holder ☐ Self ☐ Other, please name __________ Relation?______

Vision Insurance Name ____________ **ID #** ____________

Name of primary card-holder ☐ Self ☐ Other, please name __________ Relation?______

How did you hear about us?

☐ Referral from friend/family ☐ Passed by/Walked-in ☐ Search engine; website/FaceBook ☐ Other ________

If you were referred by someone, whom may we thank? ____________

Please Note: All fees paid for professional services are non-refundable and are payable at the time of the service. Patient/guardian authorizes that payment of medical and vision insurance be made to Prime Eye Center for services provided. Patient is financially responsible for co-pay/deductible or any charges not paid by insurance.

________________ __________
Patient's signature (Parent or legal guardian if patient is under 18 years old) Date

PRIME EYE CENTER

Medical Release Authorization and Insurance Assignment

All insurances must be pre-approved prior to your examination. If we are unable to verify coverage, all charges must be paid in full when services are rendered. If you are not eligible for insurance benefits or are eligible for less than full coverage, you agree to be financially responsible for any unpaid balance. If you discover that you have insurance after services are rendered, it is your responsibility to file your own claim for reimbursement. The doctor's office will not back file claims, post authorize, or refund fees. You also acknowledge that certain examinations and examination findings may not fall into the realm of a routine eye exam, and may deem to be medically necessary to file under your medical/health insurance or will need to be referred to another office. You also authorize the release of any medical or other information to process insurance claims.

________ Patient Initial Here

Acknowledgement of Review of Notice of Privacy Practices

We are required by law to protect the privacy of patients' medical information and to provide notice of our privacy practices. In the process of providing services requested, we will collect, use, and share certain information provided by the patient.

- TREATMENT: We are permitted to use and disclose your medical information to those involved in your treatment, including but not limited to hospital staff, primary care physicians, and specialists.
- PAYMENT: We are permitted to use and disclose your medical information to bill and collect payment for services provided to you.
- DISCLOSURES WITHOUT PATIENT AUTHROIZATION: There are situations in which we are required by law to disclose or use your medical information without written authorization or opportunity to object. These include, but are not limited to: public health activities, abuse/neglect, health oversight, legal proceedings, law enforcement, or as otherwise required by law.
- RESTRICTIONS: You may request that we restrict or limit how your protected health information is used or disclosed for treatment, payment, or health care operations. We do not have to agree to this restriction, but if we do agree, we will comply with your request except under emergency situations.

I have reviewed the office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document. A full copy of the office's Notice of Privacy Practices can be downloaded at **www.primeeyecenter.com**

________ Patient Initial Here

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Signature of Patient or Guardian   Date

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Printed Name of Patient or Guardian