THE EYE PLACE
WHERE OUR FOCUS IS YOU

PATIENT NAME:_____ PATIENT NUMBER:_____

*Preferred Language*_____ *Race/Ethnicity*_____

*Social Security Number*_____ *Email:*_____

Date of Birth:_____ How often do you change your contacts?: *Monthly / Daily*

Do you wear contacts or glasses?: _____ Contact lens brand?:_____

What are your computer and electronic device habits? How many hours a day do you spend on them?:

_____

Do you have any questions you would like to ask your doctor or technician today?: _____

_____

INSURANCE INFORMATION

*Name of primary insurance holder:*_____

Primary insurance holder employer: _____

Primary insurance holder SSN : _____

*Primary insurance holder's D.O.B.*_____

***Have you ever been diagnosed or treated for a disease of the following systems? If yes, please list*:**

FAMILY HISTORY/RELATIONSHIP

High Blood Pressure YES/NO _____

Diabetes YES/NO _____

Cancer YES/NO _____

Cataracts YES/NO _____

Glaucoma YES/NO _____

Macular Degeneration YES/NO _____

Yes/No *Cardiovascular* (High blood pressure, High Cholesterol, etc)_____

Yes/No *Endocrine* (Diabetes, Thyroid, etc) _____

Yes / No *Skin* (Rash, Eczema, etc)_____

Yes/No *Genitourinary* (Kidneys, Ovaries, etc) _____

Yes/No *Lungs* (Asthma, COPD, etc)_____

Yes/No *Blood* (HIV, Sickle Cell, etc) _____

Yes/No *Psychiatric* (Depression, ADHD, etc) _____

Yes / No *Gastrointestinal* (Ulcers, Crohn's, etc) _____

Yes / No *Muscle/Bone* (Arthritis, Fibromyalgia, etc)_____

Yes / No *Neurological* (Parkinson's, Seizures, etc)_____

Do you use tobacco products? **Yes / No** Could you be or are you pregnant? **Yes / No**

Allergies to Medications? **Yes / No** If yes, please list_____

Do you consent for The Eye Place to use our Electronic Health Records system to pull your medication and pharmacy information for your visit?

Yes **No** Initial:_____

Tech:_____ Dr:_____ Date:_____ **Tech:_____ Dr:_____ Date:_____**

PATIENT NAME:_____ PATIENT NUMBER:_____

HIPAA, APPOINTMENT CANCELLATION, and NO SHOW POLICY

Most insurance policies pay only a portion of your total charges. If you have any questions about your coverage, please contact your representative. We do not guarantee the accuracy of benefit information given to us by insurance companies! Please understand that financial responsibility for your account is yours, not the responsibility of your insurance company. I authorize the release of any medical or other information necessary to process insurance claims. I authorize payment of medical or vision benefits either to the physician or supplier of services rendered or to myself if the provider does not accept assignment. I understand that I am responsible for any balance my insurance does not pay. Should the account be referred to collections, the undersigned shall pay reasonable attorney's fees, court costs and collecting expenses.

_____ **(Initial)** I have read and understand the HIPAA Privacy Policy. A copy is available upon request.

(Optional) I give permission to The Eye Place to share my medical information with _____ (name) _____ (relationship).

Effective June 6, 2017

- Any patient who fails to show for an appointment or cancels/reschedules an appointment with **less than 24 hours (1 business day) notice** with be considered a No Show and will be charged a **$25 fee**.
- Any patient who has had 3 appointments that are considered a No Show appointment may be dismissed by The Eye Place from the practice.
- The fee is charged to the patient, not the insurance company, and is due within 30 days of the missed appointment.
- The Eye Place can be reached by phone or email and the numbers are located below.

We understand that there may be times when an unforeseen emergency or an extenuating circumstance occurs and you may not be able to keep your appointment. If such an instance occurs please contact our Front Office Coordinator or the Practice Manager who may be able to waive the No Show fee. You can contact The Eye Place during our regular business hours via phone/text and after our regular business hours via voicemail. There is also an office email that is checked throughout the day during our regular business hours. We will receive messages via voicemail/text and email and respond to them in a timely manner during regular business hours. Signing this document also acknowledges that the above information, as well as your contact information, is correct to the best of your knowledge.

812-379-9893

theeyeplacesite@gmail.com

Printed Name of Patient/Guardian* :_____

(*Name of parent, guardian, or spouse responsible for charges on account if not self)

Signature:_____

Date:_____