Patient name

Ocular History
Do you currently have or have you ever had any of the following problems?

	No	In the past	Now
Eye injury			
Eye pain			
Light Sensitivity			
Excess Tearing			
Red Eyes			
Dry Eyes			
Itchy eyes			
Eye infections			
Blurred Vision			
Cataracts			
Glare			
Double Vision			
Fluctuating Vision			
Loss of side vision			
Droopy Lids			
Macular Degeneration			
Glaucoma			
Keratoconous			
Corneal Disease			
Crossed/Lazy Eye			
Eye surgery			
Contacts			
Other			

Health History
Do you currently have or have you ever had any of the following problems?

	No	In the past	Now
Anemia			
Anxiety			
Arthritis			
Cancer			
Depression			
Diabetes			
Dry Mouth			
Emphysema			
Headache			
Heart Disease			
Hepatitis			
HIV			
High Cholesterol			
High Blood Pressure			
Lupus			
Multiple Sclerosis			
Pregnancy			
Sjogrens Disease			
Skin Cancer			
Stroke			
Thyroid Disease			
Unintentional Weight Loss			
Other			

Family History

	Mother	Father	Sister	Brother
Cancer				
Cataracts				
Glaucoma				
Heart Disease				
High Blood Pressure				
Macular Degeneration				

Social History	No	Yes	How much?	How often?
Do you smoke?				
Do you drink alcohol?				
Recreational drugs?				

What is the main reason you are seeing the doctor today?

Financial Policy

We are committed to providing you with the best possible care, and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. We must emphasize that as health care providers our relationship is with you, not your insurance company.

- We will process claims with insurance carriers with which we have a contract, according to that agreement.
- Your insurance is a contract between you, your employer, and the insurance company.
- We request that your required co-payments and refraction fees be made on the day service is provided.

Payment for service is due at the time service is rendered, unless arrangements have been approved in advance by our Patient Accounts Department. You are responsible for timely payment of your account. If you experience financial problems which may affect timely payment of your account we encourage you to contact our office.

Please read and initial the following statements: **Initial**

I understand the applicable co-pays are due at each visit ________

I understand that it is my responsibility to provide my insurance card to be copied. If I do not provide my card within 3 days of my visit, I understand that I am responsible for the balance incurred. ________

I understand that it is my responsibility to notify the office of any changes in insurance or personal information. ________

I am aware that knowledge of my benefits is ultimately my responsibility. The Eye Center cannot guarantee coverage of benefits by my insurance company. ________

I agree to pay $25 for any missed or canceled appointments within 24 hours of the exam. ________

I voluntarily consent to the examination and treatment of the above dependent (if applicable) or myself. ________

I authorize the release of any medical information necessary for treatment or in order to process insurance claims. __________

I understand that late payments may be subject to an additional service fee including but not limited to all costs of collections. ________

Thank you for understanding our financial policy. If you have any questions about the above information, please feel free to ask us. We are here to help you.

By signing below, I acknowledge that the information I have provided is complete and accurate:

Signature : ____ Date : ________________________