Clarion Optometry Group, Prof Corp

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We welcome you to our practice, thank you for choosing us! Please take a moment to complete this form.

Patient Name: _____ M__ F___ DOB: _____ SSN: _____

Address: _____ City: _____ State: _____ Zip: _____

Responsible Party Name: _____ Mother / Father Same Address? Y / N

Home Ph: ____-____-_____Work Ph: ____-____-_____Cell: ____-____-_____ Text? Y / N **E MAIL:**_____

Insurance Provider: _____

Subscriber Primary Insured Name: _____ Subscriber DOB: _____Subscriber SSN: _____

Married_____ Single_____ Other_____ Pharmacy you Prefer to use:_____City:_____

Who may we thank for referring you to our practice? _____

Family Doctor: _____ How can we help you see better today? _____

_____ (initials) Contact lenses require additional testing and evaluation, thus there is an additional fee for our contact lens patients. Our fee for these services ranges from **$55 to $105**. We will notify you of your exact fee before we provide this service. You have 6 weeks to finalize Contact lens prescription included in this fee.

ALL FEES INCLUDING INSURANCE COPAYS ARE DUE AT TIME OF SERVICE:_____ (INITIALS)

Please list all of your current medications: _____

Medication allergies? Y / N If yes, please specify: _____

The following pertains to your visual symptoms and health history. Please check all that apply.

SEIZURE DISORDER YES_____ NO_____ Hepatitis: _____Yes Type:____None:_____ HIV: Yes: _____ None:_____

Height: _____ Weight: _____

# of hours spent daily on a computer:_____

VISION With RX:___ No RX :___
- Distance vision blurred
- Near vision blurred
- Teary/watery eyes
- Itchy eyes
- Burning eyes
- Dry eyes
- Double vision
- See flashing lights
- Floaters or spots
- Macular degeneration In family
- Glaucoma

IMMUNOLOGIC None
- Rheumatoid arthritis
- Lupus
- Other

CONSTITUTIONAL None
- Weight loss or gain
- Fever
- Fatigue
- Other

HEMATOLOGIC None
- Anemia
- Leukemia
- Other

MUSCULOSKELETAL None
- Fibromyalgia
- Osteoarthritis
- Ankylosing Spondylitis

RESPIRATORY None
- Cigarette smoker
- Asthma
- Emphysema
- Other

CARDIOVASCULAR None
- Diabetes
- Hypertension- (High Blood Pressure)
- Vascular disease
- Other

EAR, NOSE AND THROAT None
- Respiratory tract infection
- Meds
- Other

GASTROINTESTINAL None
- Crohn's disease
- Colitis
- Ulcer
- Other

PSYCHIATRIC None
- Depression
- Schizophrenia
- Other

_____ (initials) I understand that the benefits quoted to me are not a guarantee of payment and that I am responsible for all of my out of pocket expenses at the time of service. I understand that payment by my insurance company is based on my eligibility and coverage at the time services are rendered. I authorize payment by my insurance directly to *Clarion Optometry Group Prof Corp*.

The undersigned patient hereby authorizes Clarion Optometry Group and associates to use or disclose the patient's PHI to carry out treatment, payment or health care operations on behalf of the patient. I understand the "Notice of Privacy Practices" HIPAA agreement and have been offered a copy of it.

Patient Signature: _____ Date: _____

FOR OFFICE USE ONLY - REVIEWED BY DOCTOR

Initials _____ Date_____ Initials _____ Date_____ Initials _____ Date_____