Date_____ Primary Care Physician_____

PATIENT INFORMATION

Patient's name:_____ Parent's Name (if minor):_____ Marital Status: S D M OTHER

Email Address:_____ Birth date:_____Age:_____Sex:____ Race:_____ Ethnicity:_____

Home Phone:_____ Cell Phone:_____ SS#:_____Pref. Language_____

Address:_____ City_____State _____ Zip_____

Employer:_____Employer Phone:_____ How would you like Confirmations & Appointment Reminders sent? Text or Email

INSURANCE INFORMATION

Person Responsible for bill not paid by insurance:_____ Birth date:_____

Address (if different):_____ Home Phone:_____

Employer:_____ Employer Address:_____ Employer Phone:_____

Vision Insurance Provider:_____Relationship to patient:_____

Subscriber's name:_____ Subscriber's SS#:_____Policy No._____ Group No._____

Medical Insurance Provider:_____ Relationship to patient:_____

Subscriber's name:_____ Subscriber's SS#:_____Policy No._____ Group No._____

EYE HISTORY

List <u>all medications</u> you are taking:

_____

_____

Do you have any allergies to any medications? Yes No

If "Yes", please list:

_____

Date of last eye exam: _____

Have you ever had surgery to your eyes before? Yes No

Have you or anyone in your family been diagnosed with:

	Yes	No	Explain: Self and/or family member
Glaucoma	____	____	_____
Color Blindness	____	____	_____
Blindness	____	____	_____
Cataracts	____	____	_____
Macular Degeneration	____	____	_____

Worn Glasses before: Yes No

Worn Contacts before: Yes (Soft or Hard) No

Do you drink alcohol? Yes No

Do you smoke? Yes No

Assignment of Benefits and Privacy Practices Acknowledgement

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

I hereby assign all medical and/or optical benefits, to include major medical benefits which I am entitled, including Medicare, Medicaid, Private Insurance, and other health plans to: Drs. Pratt & Russ.

I also understand that should legal action be required to collect this bill, I will be responsible for attorneys fees and court costs.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original . I understand that I am financially responsible for all charges whether or not to be paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

SIGNATURE _____ Date:_____

(Patient or legal guardian)