provision EYECARE

Patient Name: _____ Today's Date: _____
First/MI/Last

Nickname: _____ Date of Birth: _____

Address: _____ Gender: ☐ Male ☐ Female

City: _____ State: _____ Zip Code: _____ SSN: _____

Cell Phone: (_____) _____ Employer/School: _____

Home Phone: (_____) _____ Occupation: _____

Work Phone: (_____) _____ Are you: ☐ Single ☐ Married

Email: _____ ☐ Divorced ☐ Widowed

Prefered way of communication: ☐ Phone ☐ Email
Use Email for ☐ Recall ☐ Promotions

Emergency Contact: _____

Relationship: _____

Who is responsible for this account: _____

Who may we thank for referring you? _____ Phone: (_____) _____

Race: ☐ Decline to Specify ☐ American Indian/Alaska Native
☐ Asian ☐ Black/African American ☐ White
☐ Native Hawaiian or Other Pacific Islander

Ethnicity: ☐ Decline to Specify
☐ Hispanic or Latino
☐ Not Hispanic or Latino

Prefered Language: _____

Insurance Information

Do you have Vision Insurance? ☐ Yes ☐ No Card must be present at time of service

Insurance Company: _____ ID# _____

Group # _____ Primary Member: _____

Primary DOB: _____ Primary SSN: _____

Employer: _____ Relationship to Primary: _____

Primary's Address (if different than patient) _____

Do you have Health Insurance? ☐ Yes ☐ No Card must be present at time of service

Insurance Company: _____ ID# _____

Group # _____ Primary Member: _____

Primary DOB: _____ Primary SSN: _____

Employer: _____ Relationship to Primary: _____

Primary's Address (if different than patient) _____

I give permission to Provision Eyecare for the following person to have access to my information, medical and/or financial:

Name: _____ Phone: (_____)_____

Personal and Family Health History

Have you or any immediate family member (parent, grandparent, sibling) had any of the following conditions? **S** - self **F** - family

	S	F		S	F		S	F		S	F
Anxiety	□	□	COPD	□	□	Hepatitis (Type _____)	□	□	Poor Color Vision	□	□
Atrial Fibrillation	□	□	Coronary Artery Disease	□	□	High Blood Pressure	□	□	Prostate Cancer	□	□
Arthritis	□	□	Depression	□	□	High Cholesterol	□	□	Radiation Treatment	□	□
Artificial Heart Valve	□	□	Diabetes (Type _____)	□	□	Hyperthyroidism	□	□	Retinal Disease	□	□
Artificial Joints	□	□	Drug Sensitivity	□	□	Hypothyroidism	□	□	Rheumatic Fever	□	□
Asthma	□	□	Emphysema	□	□	Kidney Disease	□	□	Seizures	□	□
BPH	□	□	End Stage Renal Disease	□	□	Lazy Eye	□	□	Shingles	□	□
Breast Cancer	□	□	Epilepsy	□	□	Leukemia	□	□	Skin Condition	□	□
Bleeding	□	□	Eye Injury	□	□	Lung Cancer	□	□	Stroke	□	□
Blindness	□	□	GERD	□	□	Lupus	□	□	Thyroid Condition	□	□
Cancer	□	□	Glaucoma	□	□	Lymphoma	□	□	Tuberculosis	□	□
Chemical Dependency	□	□	Hay Fever	□	□	Macular Degeneration	□	□	Other_____	□	□
Colon Cancer	□	□	Hearing Loss	□	□	Migraines	□	□	_____	□	□
			Heart Condition	□	□	Pacemaker	□	□	_____	□	□

Please list all Medications:

_____

_____

Please list all Allergies:

_____

_____

List any Previous Surgeries:

_____

_____

Do you smoke? ☐ Yes ☐ No If, yes, how much? _____

Do you drink alcohol? ☐ Yes ☐ No If, yes, how much? _____

Privacy Practices

Due to HIPPA law and Provision Eyecare's respect for your privacy, Provision Eyecare will never share your personal information with any outside or associate that is not directly related to your care. Provision Eyecare's intended use for your information is to provide you the most up-to-date information regarding health and product concerns that may impact your vision, and to provide open communication about your account with prompt billing information. By signing below you agree that Provision Eyecare, the staff at Provision Eyecare, and its billing affiliates has: 1) your full consent to treat as they see medically necessary, 2) express written consent to contact you at the phone numbers and email addresses provided, 3) given you a copy of Provision Eyecare's Notice of Privacy Practices for all the doctors and staff associated with your services, 4) your assurance that you will assume full responsibility for any balances left unpaid by insurance.

_____

Signature of Patient or Guardian Date