Associates in Eyecare
OPTOMETRISTS, PC

WELCOME BACK FORM

Date: _____

Patient Information

Last Name: _____ First Name: _____ MI: _____

Preferred Name: _____ SS#: _____

Birth Date: _____ Age: _____ Gender: _____

Street: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

Occupation: _____ Employer/School: _____

Medical Insurance Information

Medical Insurance Plan: _____ Member ID: _____

Phone Number: _____ Vision Ins. Plan: _____

Account Responsible Information ☐ Check box if patient is acct responsible

Last Name: _____ First Name: _____ MI: _____

Street: _____ City: _____ State: _____ Zip: _____

Birth Date: _____ Relationship to Patient: _____

SS#: _____ ****Please be sure to provide us with a copy of your medical insurance card.**

Medical & Ocular History

Reason for today's visit:	☐ New Glasses ☐ Lasik	☐ Contact Lenses ☐ Failed Vision Screening	☐ Dry Eyes ☐ Other	☐ Diabetic Exam
Ocular Health Changes	☐ No	☐ Yes		
Medical Health Changes	☐ No	☐ Yes		
Current Medications	Please List: _____			
Allergies to Medications	☐ No	☐ Yes		
Pregnant or Nursing	☐ No	☐ Yes	If Yes, due date _____	

Payment Verification/HIPAA
If you are using vision/medical insurance coverage for today's visit: I hereby authorize Associates In Eyecare Optometrist, P.C., to retrieve or exchange any information necessary to process my insurance claim. I will receive services with the understanding in the event that any such coverage is denied, I will be held financially responsible. All deductibles, co-pays, non-covered services, and payment for materials are due on the date of service. Please acknowledge that you have read/agreed to this statement I (name printed above) have been presented with the Notice of Privacy Policy (HIPAA) of Associates In Eyecare, Optometrists, P.C. and have been offered a copy of such policy for my records.

Patient Signature (parent/guardian if minor)	Doctor Signature	Date