Eye Care of Blackfoot

CONTACT INFORMATION

Full Name_____
Street Address_____
City_____ State_____Zip Code_____
Primary Phone Number_____
May we contact you via text message? ◯Yes ◯No
Email Address_____

Emergency Contact: Name_____
Relationship_____Phone_____

PERSONAL INFORMATION

Date of Birth_____
Gender: ◯ Male ◯ Female
Marital Status: ◯ Married ◯ Single
Social Security Number_____

How did you hear about our office?
_____

Occupation_____
Employer_____
Hobbies/Interests_____

INSURANCE INFOROMATION

Primary Vision Insurance Company_____
Policy ID#_____ Group#_____
Policy Holder's Name_____ Policy Holder's Birth Date_____
Policy Holder's Employer_____ Policy Holder's Social Security#_____

Primary Medical Insurance Company_____
Policy ID#_____ Group#_____
Policy Holder's Name_____ Policy Holder's Birth Date_____
Policy Holder's Employer_____ Policy Holder's Social Security#_____

FINANCIAL POLICY

Please initial each box below signifying you have read and agree to the financial policy

_____ I understand that I am responsible for fees, co-payments, deductibles and associated charges related to my exam, the day of my appointment.

_____ I understand that I cannot receive contact lenses and/or glasses until they are paid for in full. Materials may be ordered after collecting 50% of the fee, with the remaining balance due upon receiving materials.

_____ I understand that I am responsible for payment of any remaining charges after my insurance has been billed.

PRIVACY STATEMENT

Please initial each box below signifying you have read and agree to the following statements

_____ I authorize Advanced EyeCare of Blackfoot to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child to third party payers and/or health practitioners.

_____ I acknowledge that I was offered a copy of Advanced EyeCare of Blackfoot's HIPPA policy.

_____ I authorize and request my insurance company to pay directly to Advanced EyeCare of Blackfoot benefits payable.

_____ _____
Signature of Patient/Responsible Party Date

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OCULAR HISTORY

Reason for today's visit:_____

Last Eye Exam_____ Location:_____

Primary Vision Correction: ◯Glasses ◯Contacts ◯Lasik ◯None

Age of current glasses:_____ Do you wear contacts?_____ What type? _____

Previous eye injury/surgery_____

Do you or any blood relatives have any of the following eye conditions?

	Self	Relative	Relationship:
Glaucoma	◯	◯	_____
Macular Degeneration	◯	◯	_____
Retinal Detachment	◯	◯	_____
Flashes/Floaters	◯	◯	_____
Dry Eyes	◯	◯	_____

Other:_____

Additional Eye Concerns:_____

Medical HISTORY

What is your general health:_____ Last Doctor Visit:_____

Name of family doctor:_____ Preferred Pharmacy:_____

Current Medications:_____ _____ _____ _____

Allergies:_____ _____ _____ _____ _____

Do you or any blood relatives have any of the following conditions?

	Self	Relative	Relationship:
Diabetes	◯	◯	_____
High Blood Pressure	◯	◯	_____
Thyroid Disease	◯	◯	_____
Heart Disease	◯	◯	_____
Autoimmune Disease (specify)	◯	◯	_____
Cancer (specify)	◯	◯	_____

Other:_____

Diabetes: Type:_____Year of Diagnosis:_____Blood Sugar Range:_____Last A1C:_____