Frechette Eye Center

Date: / /

Personal Information

Sex: ❑ Male ❑ Female

Patient Name: ❑Single ❑ Married ❑ Widowed ❑ Divorced Age: Birthdate:

Address: City: State: Zip Code:

Home Phone: Business Phone: Occupation: Employer:

Name of Parent/Spouse: Grade/ If Student:

E-mail Address: S.S.N. # Have we seen other family members? Yes ❑
Whom? No ❑

Medical and Visual History

Name of Physician and City: Last Eye Doctor and City: Last Eye Exam:

List any Medications you are taking:

❑ None

List any Medication Allergies:

❑ None

Check any Medical Conditions that apply to you:

❑ Diabetes ❑ Allergies ❑ Ear/Nose/Throat Problems ❑ Arthritis ❑ None
❑ Headaches ❑ Cancer ❑ Psychiatric Problems ❑ Heart Disease
❑ Skin Problems ❑ Gastrointestinal Problems ❑ High Blood Pressure ❑ Lung Cancer

Check any Eye Conditions that apply to you:

❑ Eye Surgery ❑ Glaucoma ❑ Cataracts ❑ Dry Eye ❑ Macular Degeneration
❑ Lazy Eye ❑ Light Flashes ❑ Floaters ❑ Turned Eye ❑ Past Eye Injury

Check Conditions that are present in other family members (Parents, Grandparents, Siblings)

❑ Glaucoma ❑ Heart Disease ❑ High blood Pressure ❑ Other _____
❑ Diabetes ❑ Cancer ❑ Macular Degeneration

Contact Lens History

❑ Currently Wearing Contacts ❑ Not Interested in Contacts
❑ Would Like to Know if I could wear Contacts ❑ Problems with Contacts _____

Type of Contacts Worn

❑ Daily Wear ❑ Rigid Gas Permeable ❑ Disposable/Frequent Replacement
❑ Extended Wear ❑ Bifocal ❑ Other_____

Activities and Interests

❑ Contact Sports ❑ Computer_____hrs./day ❑ Basketball/Volleyball ❑ Reading
❑ Sewing/Crafts ❑ Baseball/Softball ❑ Soccer ❑ Other_____

How did you find out about our office?

❑ Insurance List ❑ Phone Book ❑ Newspaper ❑ Direct Referral ❑ Other_____

Insurance Release

I Hereby authorize Frechette Eye Center to apply for benefits on my behalf for services rendered by them, or by their order. I request that payment from my insurance company be made directly to Frechette Eye Center. I understand that I am responsible for all unpaid charges.

I certify that the information I have reported with regard to my insurance coverage is correct.

I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

_____ _____

Signature Date

Patient Responsibility

I understand that all charges are to be paid in full at the time of service unless I present a valid insurance card that represents insurance carriers that Frechette Eye Center has contractual agreements. All deductibles, co-pays, and noncovered services are expected to be paid at the time of service.

In the case of children whose responsible party is someone other than the custodial parent, we must ask that the payment be made at the time of service by the person accompanying that child to the office.

_____ _____

Signature Date

Medicare Release

I request that payment of authorized medicare benefits be made either to me or on my behalf to Frechette Eye Center for any services furnished me by that Optometrist. I authorize any holder of medical information about me to release to the health care financing administration and its agents any information needed to determine these benefits.

_____ _____

Signature Date

Medigap Release

I request that payment of authorized medigap benefits be made either to me or on my behalf to Frechette Eye Center for any services furnished me by that Optometrist. I authorize any holder of medical information about me to release to my medigap carrier any information needed to determine these benefits.

_____ _____

Signature Date

FRECHETTE EYE CENTER

ACKNOWLEDGEMENT OF RECEIPT

I understand that under the Health Insurance Portability & Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information.

I further authorize Frechette Eye Center to discuss my test results and financial and/or insurance situation regarding my incurred charges with:

Name	Relationship	Phone
Name	Relationship	Phone

I acknowledge that I received a copy of Frechette Eye Center's Notice of Privacy Practices.

Date _____

Print name_____

Relationship to patient _____

Signature _____

Office Use Only

I attempted to obtain the patient's signature in acknowledgment on this Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date _____ Initials _____

Reason _____