PATIENT FORM

GENERAL INFORMATION

First, Last, MI, Preferred Name

Street Address

City, State, Zip

Phone, Type

Phone 2, Type

Email

Preferred Contact Method *cell phone* | *email* | *text* | *other (please explain)*

Patient Social Security Number

Date of Birth

Male/Female

Occupation/Employer *full-time* | *part-time*

Marital Status *married* | *single* | *divorced* | *legally separated* | *widowed*

Language, Race, Ethnicity

Emergency Contact Person and Phone

INSURANCE INFORMATION

Vision Insurance

Vision Insurance Member Name

Vision Insurance Member ID#

Vision Insurance Member Date of Birth

Primary Medical Insurance

Primary Member Name

Insurance ID#

Insurance Policy#/Group ID#

Primary Member Date of Birth

Primary Member Social Security Number

Primary Member Employer

Your Relationship to Primary Member *spouse* | *child* | *other (please explain)*

Secondary Medical Insurance

Secondary Medical Insurance Member Name

Secondary Medical Insurance ID#

Secondary Medical Insurance Policy #/Group ID#

Secondary Medical Insurance Member Date of Birth

Secondary Medical Insurance Member Social Security Number

Your Relationship to Secondary Medical Insurance Member

PATIENT FORM

EYE HISTORY

Date of Last Eye Exam

Currently Wear Glasses?

Currently Wear Contacts?

Reason for Today's Visit

Have you or a family member experienced, or been treated for, any of the following? Circle all that apply.

Cataracts	*yes*	*no*	*family*
Crossed Eye	*yes*	*no*	*family*
Glaucoma	*yes*	*no*	*family*
LASIK or RK	*yes*	*no*	*family*
Lazy Eye	*yes*	*no*	*family*
Macular Degeneration	*yes*	*no*	*family*
Retinal Detachment	*yes*	*no*	*family*

Are you currently experiencing, or have experienced, any of the following? Check all that apply.

- ☐ Blurry Vision *near or distance*
- ☐ Burning
- ☐ Discharge
- ☐ Double Vision
- ☐ Dryness
- ☐ Excess Tearing/Watering
- ☐ Eye Infection
- ☐ Eye Pain or Soreness
- ☐ Floaters or Spots
- ☐ Halos
- ☐ Headaches
- ☐ Itching
- ☐ Light Flashes
- ☐ Light Sensitivity
- ☐ Redness
- ☐ Sandy or Gritty Feeling

MEDICAL HISTORY

Have you or a family member experienced, or been treated for, any of the following? Circle all that apply.

AIDS/HIV	*yes*	*no*	*family*
Allergies	*yes*	*no*	*family*
Arthritis	*yes*	*no*	*family*
Asthma	*yes*	*no*	*family*
Blood/Lymph Disorder	*yes*	*no*	*family*
Cancer	*yes*	*no*	*family*
Diabetes	*yes*	*no*	*family*
Ears, Nose, Throat Conditions	*yes*	*no*	*family*
Gastrointestinal Conditions	*yes*	*no*	*family*
Heart Disease	*yes*	*no*	*family*
High Blood Pressure	*yes*	*no*	*family*
High Cholesterol	*yes*	*no*	*family*
Kidney Disease	*yes*	*no*	*family*
Lupus	*yes*	*no*	*family*
Neurological Conditions	*yes*	*no*	*family*
Psychiatric Disorder	*yes*	*no*	*family*
Seizures	*yes*	*no*	*family*
Skin Conditions	*yes*	*no*	*family*
Stroke	*yes*	*no*	*family*
Thyroid Dysfunction	*yes*	*no*	*family*

Current Medications (prescription and over-the-counter and dosage)

Medication Drug Allergies

Height **Weight**

Are you pregnant or nursing?

Do you smoke?

Have you ever smoked?

ADVANCED VISION CARE
Michael Matthews, O.D.
2926 Hillrise Drive
Las Cruces, NM 88011
575-522-6885

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED

This consent form allows us to use and disclose your health information for purposes of treatment, payment, and health care operations of this office.

We use information for treatment purposes, when, for example, we set up an appointment for you and call to remind you of scheduled appointments, when our doctor tests your eyes, when the doctor prescribes glasses or contact lenses, when the doctor prescribes medication, and when our staff helps you select and order glasses or contact lenses. We may disclose your health information outside of our office for treatment purposes if, for example, if we refer you to another doctor or clinic for eye care, if we send a prescription for glasses or contacts out to be filled, when we provide a prescription for medication to a pharmacist, or when we phone to let you know that your glasses or contact lenses are ready to be picked up.

We use your health information for payment purposes when, for example, our staff asks you about vision care plans that you may belong to, or about other sources of payment for our services, when we prepare bills to send to you or your vision care plan, when we process payment by credit card, and when we try to collect unpaid amounts due.

We may disclose your health information outside of our office for payment purposes when, for example, bills or claims for payment are mailed, faxed, or sent by computer to you or vision plan, or when we occasionally have to ask a collection agency or attorney to help us with unpaid amounts due.

It is completely your decision whether or not to sign this authorization form. **Please note that if you choose not to sign, we cannot release your information to your insurance company, thus we cannot bill them and will need to charge you for the full amount of this visit today.**

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization.

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient Name_____

Patient Address_____

Patient Phone Number_____

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Patient Signature _____ **Date** _____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority (if other than parent) to sign this form:

Relationship to Patient _____ **Print Name** _____

Source of Authority _____