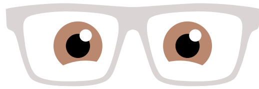


EYECARE
ASSOCIATES

NEW PATIENT FORM

First Name: ____________ Middle Initial ____ Last Name ____________

Nick Name: ____________ Male or Female Age: ____________

Mailing Address: ____________ Date of Birth: ____________

City: ____________ Zip Code: ____________ SSN : ____________

Phone Number: ____________ Employer: ____________

Daytime Phone # ____________ Occupation: ____________

Cell Phone #: ____________ Employed: Full Time or Part Time

Do you accept text messages? Yes or No Marital Status: ____________

Email: ____________ Spouse: ____________

Language Preference English Spanish Please contact me by: Phone Email Mail

Race (Please circle): African American Native American or Alaska Native Asian
Caucasian/ White Hispanic Native Hawaiian/Other Pacific Islander

Parent or Guardian Name (if patient is under 18) ____________

Please tell us how you heard about us:

- o Facebook
- o Yellow Pages
- o Drove By
- o Insurance Company
- o Yelp
- o Internet (where?) ____________
- o Friend/Relative (name?) ____________
- o Doctor (name?) ____________
- o Brochure/Flyer (from?) ____________
- o Other(Please specify) ____________

Bill to: Name and Address (If different from patient) ____________

____

Insurance Information

Insurance Company: ____________ Subscriber ID: ____________

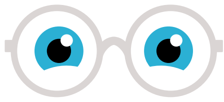
Subscriber Information (if different than patient)

Name: ____________ Birth Date: ____________ SSN: ____________

Male or Female Relationship to Patient: ____________ Employer: ____________

Vision Benefits? Yes or No If yes, through which company? ____________

Please see reverse for medical history



EYECARE
ASSOCIATES

MEDICAL HISTORY

Date of last eye exam: ______________ Pregnant or Nursing: Yes or No

Primary Care Physician: ______________ Referring Physician: ______________

Do you currently wear contacts? Yes or No If no, would you like to try contacts? Yes or No

If yes, what kind? ______________ Are you satisfied with them? Yes or No

What is the primary reason for your visit today? ______________

Please list any previous eye surgeries: ______________

Please list all medications (including over the counter): ______________

____

____

Allergies to medications: ______________

Tobacco Use: Yes or No Current or Past If yes, how much? : ______________

Please list if <u>you</u> or a <u>relative</u> have ever been diagnosed ot treated for the following:

Ocular History	Relationship	Medical History	Relationship
Cataracts	______	Allergies	______
Corneal Problems	______	Asthma	______
Diabetes	______	Cancer	______
Dry Eyes	______	Cholesterol	______
Eye Injuries	______	Migraines	______
Flashes of Light	______	High Blood Pressure	______
Glaucoma	______	Lupus	______
Macular Degeneration	______	Stroke/TIA	______
Ocular Allergies	______	Hepatitis A B C (circle one)	______
Double Vision	______	Kidney Problems	______
Cross/Eye turn	______	Multiple Sclerosis	______
Floaters	______	Tuberculosis	______
Retinal Issues	______	Thyroid (hypo or hyper?)	______
Other	______	Other	______

Do you… (please check if answer is yes)

- ○ Work at a computer?
- ○ Have sunglasses?
- ○ Have problems with glare at night?
- ○ Want lenses that change from light to dark?
- ○ Want information about LASIK?
- ○ Want to try colored contacts?
- ○ Want information about no-line bifocals?
- ○ Want more information about contacts?

Signature of Patient or Guardian: ______________ Date ______________

Brian Mitchell, OD | Tessa Johnston, OD | Damon Hanson, OD

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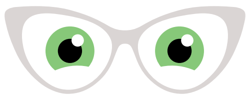

FINANCIAL RESPONSIBILITY

Patient's Name____ **Date of Birth** _______________
(Please print)

Cell Phone Number: ______________________________ **Texting ok? Yes or No**

Email Address (please print legibly)____

Mailing Address____

It is our office policy to inform you of our payment procedures. Please review and initial the section below that is applicable. **All accounts not paid within 60 days are subject to a 1.5% interest charge.**

Contact lens services fees are subject to additional fees that are not listed below.

________ 1. **Patient without Insurance (Private Pay)**

Please make payment for your care at each visit. If payment cannot be made at each visit, arrangement must be made with our billing department prior to your visit.

________ 2. **Patient with Insurance**

You are responsible for deductibles, co-pays, non-covered services (such as the **Optomap** which is $39), co-insurance, and items considered "not medically necessary" by your insurance company. Please pay co-payments and co-insurance amounts as services are rendered. The remaining balance should be take care of within one(1) month of notice from insurance company unless other arrangements are made with our billing department. If you or your insurance carrier make payment exceeding your balance, reimbursement will be remitted. If payment cannot be made at each visit, notify the billing department to make other arrangements.

________ 3. **Medicare**

Our office will submite your Medicare charges to Medicare and your secondary insurance. You are responsible for deductibles, copays, and any non-covered services sush as the **refraction ($20)** and the **Optomap ($39)**.

I have read and agree to the financial policy information stated above that applies to me.

____ ____________________
Patient (or responsible party) signature Date

____ ____________________
Person signing on behalf of patient (please print name) Relationship to patient

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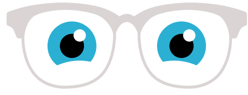

HIPAA CONSENT: PATENT PRIVACY

We are required by law to protect the privacy of your medical information, and to provide you with written notice describing how medical information about you may be used and disclosed, and how you can access this information.

We may use or disclose to others your medical information for purposes of providing or arranging for your health care and the related administrative activities supporting your treatment.

We may be required or permitted by certain laws, regulations, or circumstances to use and disclose your medical information for certain purposes without your authorization. Under other circumstances, we may need your written authorization (that you may later revoke) in order to use or disclose your medical information.

As our patient, you have important rights relating to inspecting and copying your medical information that we maintain, amending or correcting that information, obtaining and accounting of our disclosures of your health information, and complaining if you think your rights have been violated.

We have available a detailed Notice of Privacy Practices which fully explains your rights and our obligations under the law. We may revise our notice from time to time.

You have the right to receive a copy of our most current Notice of Privacy Practices in effect. If you wish to receive a copy, please ask at the front desk, and we will provide you with a copy.

I consent to Eyecare Associates of Southern Oregon, PC's Notice of Privacy Practices

Patient Name: ____

Signature: ____ Date: ____________

Please list anyone you wish to have access to your records:

1.____________________________________ 2. ___________________________________

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