DeCesare EYE ASSOCIATES

Member American Optometric Association

----------PATIENT INFORMATION----------

Patient Name:_____

Guardian/Responsible Party's Name:_____

Address:_____ Social Security #:_____

City:_____ State:_____Zip:_____

Home #:_____ Cell #:_____Work #:_____

Email Address: _____ Birthdate:_____

Place of Employment:_____ Occupation:_____

Primary Health Insurance:_____ Policy#:_____

Who may we thank for referring you to us?_____

----------PATIENT MEDICAL HISTORY----------

Are you currently being treating for any health problems? Y N

High Blood Pressure? Y N Diabetes? Y N High Cholesterol? Y N

Other (Specify): _____

Please list *ALL MEDICATIONS* including eye drops:

_____

_____

Please list any allergies to medications:

_____

Is there a family history of diabetes? Y N Is there a family history of high blood pressure? Y N

Is there a family history of eye disease? Y N

Age-related Macular Degeneration? Y N Glaucoma? Y N Blindness? Y N

Do you wear contact lenses? Y N If yes, what type? _____

Briefly state the reason for today's visit:_____

PATIENT AGREEMENT

Payment is due at time of services rendered. By signing below, you agree to and understand the following policies:

HIPAA-Privacy Notice
We are required by law to provide a copy of our HIPAA Notice of Privacy Practices to each patient. Your signature below acknowledges our offer to provide a copy of this Notice of Privacy Practices to you.

_____
Initials

Electronic Communication
By supplying my home/mobile phone number, email address, and any other personal contact information, I authorize my health care provider to employ a third-party automated outreach & messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, **for the purpose of notifying me of a pending appointment, missed appointment, overdue routine eye examination, or any other reasonable healthcare related communication.** I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, limited protected health information regarding healthcare events, unpaid balances, missed appointments, and to leave a reminder message on my voice mail or answering system if I am unavailable at the number provided by me.

_____
Initials

Medical Care Agreement
I authorize the optometrists at DeCesare Eye to administer medical treatment as deemed necessary. I understand that there will be a $25.00 charge for appointments not cancelled 24 hours in advance. I understand that the primary insured is financially responsible for any balance not covered by my insurance, including co-pay, deductible/co-insurance, and any services excluded by my policy. I also understand the primary insured will be held responsible for any and all charges incurred by myself or covered dependents should there be no coverage on the date of service. Furthermore, I hereby authorize release of medical information necessary to file a claim with my insurance and assign benefits to otherwise payable to me to DeCesare Eye Associates.

_____
Initials

Signature: _____ Date: _____