Adult form

Please bring Photo ID & Medical Insurance card to front

Patient Information

Today's Date: ______________________

Last Name: ______________________

First Name: ______________________ MI: _____

Preferred name/nickname: ______________________

Patient SSN: ______________________

Gender: M F Date of Birth: ______________

Address: ______________________

City: ______________ State: _______ Zip: ________

Do you receive text messages? Yes No

Cell Phone: ______________________

Preferred number to call: Home Cell Work

Home: ______________ Work: ______________

Marital Status: Single Married Divorced Widowed

Email: ______________________

May we contact you by e-mail regarding appointments, account information or practice news? Yes No

Employer: ______________________

Occupation: ______________________

Emergency Contact: ______________________

Phone: ______________ Relationship: ______________

Privacy Practices for Health Information

The Eagleville Eye Clinic has established a *Privacy Policy* and guidelines *for Privacy Practices* within this office. A copy of these policies can be provided to you at your request.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Dr. Rena Cron & the Eagleville Eye Clinic to release any medical or incidental information that may be necessary for medical benefits or to obtain payment for services. This includes but is not limited to vision plans or medical insurances.

Who do you authorize to release to medical information to?
Name: ______________ Relationship: ______________

CONSENT FOR TREATMENT: I hereby authorize the Eagleville Eye Clinic to administer diagnostic and medical procedures as may be necessary for proper health care.

______________________ ______________
Patient Signature Date

Patient Medical History

Primary Physician: ______________________

Location: ______________________

Phone: ______________________

Date of Last Physical Exam: ______________________

Pharmacy: ______________________

Location: ______________ Phone: ______________

CURRENT MEDICATIONS (Rx or Over-the-Counter):
(List all medications including eye drops, vitamins, etc.)

____

____

Any Allergies to medications: ______________________

____

Date of Last Eye Exam: ______________________

Previous Eye Doctor: ______________________

Have you had any eye surgeries? ❑ Yes ❑ No

If so, please describe: ______________________

____

Additional Testing

To safe-guard the health of your eyes, Dr. Cron may recommend additional diagnostic testing such as digital retinal photographs, extended visual field testing or corneal pachymetry. **These diagnostic procedures are in addition to a routine eye exam and may incur additional charges.**

Payment Agreement/Insurance Authorization

We will gladly file your insurance for today's visit.
****However, we cannot guarantee payment.**

I understand that if insurance is filed for vision or medical services, all payments will be assigned directly to Dr. Rena Cron. **I understand that I am financially responsible for all charges whether or not paid by insurance**, including all collection costs and legal fees for unpaid balances.

______________________ ______________
Patient Signature Date