WELCOME BACK TO OUR OFFICE!

Oquirrh Mountain eye care

Today's Date: ____/____/____

Patient Information

Last: _____

First: _____ MI:_____

Street: _____

City: _____State:_____Zip: _____

Home Phone: _____

Cell Phone: _____

Other Phone:_____

Email address:_____

Date of Birth:_____ Age:_____ Sex: M F

Employer (or school):_____

Occupation: _____

Spouse (or parent's name): _____

Today's Visit Information

What is the MAJOR purpose of today's visit?

_____

_____

_____

Any problems with your current glasses or contacts?

_____

_____

_____

Are you experiencing any of the following symptoms? (Check those that apply)…

□ Blurred Vision (Distance / Near)
□ Dryness
□ Burning
□ Itchiness
□ Headaches
□ Glare or reflections
□ Redness
□ Trouble seeing at night
□ Flashes of light
□ Double Vision
□ Floating spots
□ Watery Eyes
□ Sensitivity to light
□ Eye Strain
□ Gritty feeling
□ Other problems: (please explain)

_____

_____

_____

Insurance Information (☐ No Changes)

Vision Insurance: _____ Co-pay $_____
Subscriber Name: _____
Subscriber SSN # or ID #: _____
Subscriber Birth Date:____/____/____ Group #: _____
Relationship to patient: _____

Medical Insurance: _____ Co-pay $_____
Subscriber Name:_____
Subscriber SSN # or ID #: _____
Subscriber Birth Date:____/____/____ Group #: _____
Relationship to patient: _____

Medical/Eye History (☐ No Changes)

Current Medications: (Rx or Over-the-Counter)
(*List name of medications including eye drops, vitamins, & birth control pills*):

_____

_____

_____

Allergies to Medications? □ Yes □ No
If yes, please list what medications:_____

_____

Do you use cigarettes/tobacco, alcohol, or other substances? □ Yes □ No

Have you ever been diagnosed or treated for any of the following health problems?

□ Diabetes
□ High Blood Pressure
□ Cancer
□ Allergies
□ Ear/Nose/Throat
□ Blood/Lymph
□ Neurological
□ Respiratory
□ Arthritis
□ Cholesterol
□ Endocrine
□ Genitourinary
□ Integumentory (skin)
□ Muscle/Bone
□ Psychological
□ Thyroid

*Is there any **Family History** of the following?*

	Relationship (Mother or Father's side)
Blindness	□_____
Glaucoma	□_____
Macular Degeneration	□_____
Lazy Eye	□_____
Retinal Problems	□_____
Diabetes	□_____
Heart Disease	□_____
Cancer	□_____
Other: _____	□_____

Please be advised if you are using insurance coverage for today's visit, this is a contract between you and your insurance company ...not Oquirrh Mountain Eye Care. Payment of all insurance co-pays and deductibles are required at the time of service. As a courtesy, this office will submit claims to your insurance carrier, however, the bill is your responsibility whether your insurance company pays or not. Any fees not covered by your insurance in 60 days will be billed to you.

I, the undersigned, give permission to release information to 3rd party carriers and do assign all insurance benefits for treatment or services to be paid directly to providers at Oquirrh Mountain Eye Care and request that this assignment remain on file with my insurance carrier. I certify that a copy of this assignment shall be as valid as the original. I recognize that the provider cannot accept responsibility for collecting any insurance claim or negotiating any settlement on a disputed claim. I also agree that in the event of default in the payment of any amount due, and if this account is placed in the hands of an agency or attorney for collection or legal action, to pay the cost of collection including agency and attorney fees and court costs incurred and permitted by laws governing these transactions. A finance charge of 1.5% per month (annual rate of 18%) may be charged on all balances over 60 days, regardless of pending insurance claims. I also confirm that all information is true and correct to the best of my knowledge.

Signature:_____ Date: _____