



WELCOME TO OUR OFFICE!

Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Insurance Information**

**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): \_\_\_\_\_

**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: \_\_\_\_\_

Do you participate in a Flex Spending account?  Yes  No

**Eye & Vision History**

**What is the MAJOR purpose of this visit?**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Do you experience (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

Date of last eye exam: \_\_\_\_\_

By Whom: \_\_\_\_\_

Current Contact Lens wearer?  Yes  No  
 If yes, which brand? \_\_\_\_\_

Are you satisfied with the vision and comfort of your current contact lenses?  Yes  No

Have you had any eye surgeries?  Yes  No  
 If yes, please list: \_\_\_\_\_

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

Relationship (Mother or Father's side)

- Blindness  \_\_\_\_\_
- Glaucoma  \_\_\_\_\_
- Macular Degeneration  \_\_\_\_\_
- Lazy Eye  \_\_\_\_\_
- Retinal Problems  \_\_\_\_\_
- Other: \_\_\_\_\_  \_\_\_\_\_

**Referral Information**

**IMPORTANT! NEW PATIENTS ONLY:**

Who may we thank for referring you to our office?

Name of friend or relative: \_\_\_\_\_

If NOT referred, how did you hear about our office?

- Another Dr.
- Insurance List
- Saw sign/building
- Newspaper ad
- Yellow pages (which directory? \_\_\_\_\_)
- Website or internet search
- Other: \_\_\_\_\_

## Medical History

Name of Family Physician: \_\_\_\_\_

**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?

- |  |   |
|--|---|
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Arthritis            |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Cholesterol          |
| <input type="checkbox"/> Cancer              | <input type="checkbox"/> Endocrine            |
| <input type="checkbox"/> Allergies           | <input type="checkbox"/> Genitourinary        |
| <input type="checkbox"/> Ear/Nose/Throat     | <input type="checkbox"/> Integumentary (skin) |
| <input type="checkbox"/> Blood/Lymph         | <input type="checkbox"/> Muscle/Bone          |
| <input type="checkbox"/> Neurological        | <input type="checkbox"/> Psychological        |
| <input type="checkbox"/> Respiratory         | <input type="checkbox"/> Thyroid              |

Is there any Family History of the following?

- |               | Relationship                   |
|---------------|--------------------------------|
| Diabetes      | <input type="checkbox"/> _____ |
| Heart Disease | <input type="checkbox"/> _____ |
| Cancer        | <input type="checkbox"/> _____ |

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:** \_\_\_\_\_