Insight EYECARE

PATIENT INFORMATION FORM

Patient Name: _____

Nickname: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ ☐ Texting is OK

Email: _____

Communication Preference: _____

☐ Phone ☐ Text ☐ Email

Date of Birth: _____ Gender: ☐ M ☐ F

Patient SSN: _____

Marital Status: ☐ Single ☐ Married

☐ Widowed ☐ Divorced ☐ Decline to Specify

Employer: _____

Occupation: _____

Race: ☐ Amer. Indian ☐ Asian ☐ Black

☐ Decline to Specify ☐ European ☐ White

☐ Other: _____

Ethnicity: ☐ Hispanic ☐ Not Hispanic

Parent/Guardian Name (if applicable): _____ Parent/Guardian DOB: _____

Emergency Contact: _____ Emergency Phone: _____

For new patients, how did you hear about us?

☐ Drive by ☐ Google ☐ Our website ☐ Vision Plan ☐ Facebook ☐ Other: _____

☐ Referred by: _____

Questions about your visit today:

Are you currently wearing glasses or contacts today? ☐ Glasses ☐ Contacts ☐ Neither

Glasses / Lasik

Are you interested in new glasses if helpful? ☐ Yes ☐ No

Are you interested in information about Lasik? ☐ Yes ☐ No

Contacts

A contact lens **examination fee** is required when first prescribing or updating a current contact lens prescription. This fee covers the additional time and any follow-up visits to fit the contacts.

Our contact lens fittings start at $60 and depend on the difficulty of the fit. Please refer to front desk staff for any pricing questions.

Are you interested in wearing/updating contacts? ☐ Yes ☐ No

Medicare and Other Medical Insurances

By signing, I understand that Insight Eyecare may bill my medical insurance if my exam is not a routine vision exam. I understand that Insight Eyecare is contracted to follow my insurance's billing rules. That may include charging a copay for each visit and that the entire balance of the visit may get applied towards my deductible (which the patient is responsible for) if my insurance plan deems proper. I understand that any service provided not covered by my medical insurance may be my responsibility.

HIPAA

By signing, I agree to and understand that this clinic complies with all requirements of HIPAA, my rights to my records and privacy. I understand that there are full copies of the HIPAA statement available at the front desk and waiting room.

I agree to and understand the policy summaries. I understand that full length copies are available and are posted.

If you would like to authorize us to share your records with anyone such as family or a guardian, list their names below. Without your authorization, we cannot disclose patient information to anyone.

Name:	Relationship to Patient:
Name:	Relationship to Patient:
Name:	Relationship to Patient:

By signing below, I confirm that these records are full and accurate to the best of my knowledge.

Signed Patient (or Parent/Guardian): _____Date: _____

Prayer Request (optional): _____

☐ Verbal prayer in exam ☐ Silent prayer