Name: ____

Mailing Address: ____

City, State, Zip Code: ____

Cell Phone: ___________________________**Daytime Phone:** __________________________________

Email: ____

Date of Birth: ________________________ **Gender: Male / Female** **Single / Married / Widow**

Patient Social Security Number: ____

Employer: ____________________________________**Occupation:**_____________________________

Preferred Contact Method: ☐ **Phone** ☐ **Mail** ☐ **Email** ☐ **Text**

How did you hear of our office? ____

Language English / Español

Race: American Indian / Asian / African American / Hispanic / Native Hawaiian / White

Responsible Adult (Primary Insurance Holder): ____

<u>This section only applies if we are filing insurance for you.</u>

Vision Insurance: Eyemed / Eyetopia / MES / VSP **Member ID:** ____________________________

- **Primary Member Name, if not self:** ____
- **Primary Member Social Security Number:** __________________**Date of Birth:** ______________

Medical Insurance: Blue Cross Blue Shield / First Care / Medicare

Member ID: ___________________________________**Group Number:** __________________________

- **Primary Member Name, if not self:** ____
- **Primary Member Date of Birth:** ____

Secondary Vision/Medical Insurance: ____

Member ID: ___________________________________**Group Number:** __________________________

- **Primary Member Name, if not self:** ____
- **Primary Member Social Security Number:** _________________**Date of Birth:** _______________
- **Patient/ Guardian Signature** ______________________________**Date:**____________________
  Relationship (if not signed by patient): ____

Medical Information

List of all Medication: ____

Do you use eye drops? (List) ______________________________ **For** ________________________________

Do you have or ever had any problems with any of the following systems *(common conditions are given in parenthesis). Please circle no or yes; list your specific condition(s), and list all medications in the space provided*

NO / YES **Allergies -Allergic to** ____

NO / YES **BLOOD/LYMPH** ____

NO / YES **Cardiovascular (Heart)** ____

NO / YES **Ear/Nose/Throat** ____

NO / YES **Endocrine (Thyroid, Diabetic)** ____

NO / YES **Gastrointestinal (Stomach-Diarrhea, Constipation, Acid Reflux)** ____

NO / YES **Genitourinary (Genitals-STD's, Kidney, Bladder)** ____

NO / YES **Heart Attack** ____

NO / YES **High Blood Pressure** ____

NO / YES **High Cholesterol** ____

NO / YES **Integumentary (Skin Conditions-Acne, Rosacea)** ____

NO / YES **Musculoskeletal (Muscle/Bones – Arthritis, Fibromyalgia)** ____

NO / YES **Nervous** ____

NO / YES **Neurological (Seizures, Headache, Migraines)** ____

NO / YES **Pregnant –If so, how far along are you?** ____

NO / YES **Psychiatric (Depression/Anxiety)** ____

NO / YES **Respiratory (Asthma, Bronchitis)** ____

NO / YES **Tobacco, Alcohol, or Illegal Drug Use** ____

Other Health Problems: ____

Diabetes Type 1 / Type 2 Date of Diagnosis: ______________________________________

Name of Health Care Physician: ______________________**Date of last visit**_____________________

Date of Last Eye Exam _____________________**Previous Eye Doctor** __________________________

Family History

Does anyone in your family have any of the following conditions? State their relation to you.

☐ **Cataracts:** _________________________ ☐ **Diabetes:** __________________________________

☐ **Glaucoma:** ________________________ ☐ **High Blood Pressure** _______________________

☐ **Macular Degeneration:** ______________ ☐ **Retinal Detachment:** ________________________

☐ **Turned/Cross/Lazy Eye:** ________________ **Other:** ____

Do you currently experience or have experienced the following (circle only if yes)

Abrasion	Blur at Distance	Blur at Near	Cataracts
Double Vision	Eyes Burn or Dry	Eyes Discharge	Eye Injury
Eye Pain/Ache	Eye Surgery	Eyes Water	Flashes/Floaters
Foreign Body	Frequent Headaches	Glaucoma	Light Bothers Eyes
Macular Degeneration	Red Eyes	Trouble seeing at Night	Trouble with Glare Distortion
Turned, Cross, or Lazy Eye	Other Eye Problem: ______________________________		

Do you wear glasses? ☐ **YES** ☐ **NO**

What do you like or dislike about your glasses? ______________________________

Do you wear contact lenses? ☐ **YES** ☐ **NO**

(CIRCLE WHICH CONTACT LENS YOU WEAR)

GAS PERMEABLE / DAILY / ASTIGMATISM / BIFOCAL / OTHER ______________________________

CONTACT LENS BRAND: ______________________________

Lifestyle Questions (Please check any that apply to you):

- ☐ Are you interested in purchasing glasses today?
- ☐ Do you have more than one pair of current prescription eyewear?
- ☐ Do you work at a computer? If so, how many hours a day? ______________________________
- ☐ Do you think you might benefit from thinner, lighter lenses?
- ☐ Do you have prescription sun wear? If so, are the polarized? ______________________________
- ☐ Are you interested in information on Laser Vision correction surgery?
- ☐ Do you have family members in need of eye care?
- ☐ What are your hobbies? ______________________________

Patient Signature: ______________________________ **Date:** ______________________

Doctor Signature: ______________________________ **Date:** ______________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I have been presented with a copy of the Notice of Privacy Practices outlining my rights regarding my health information and detailing how my health information may be used and disclosed as permitted under federal and state law.

By law, without your authorization, Drs Webb & Webb Optometrists cannot communicate with:

- Your spouse
- Your adult children or caregivers
- Your parents (if age 18 or older)
- Your other healthcare physicians

Indicate below the names of the people who we may communicate with regarding your appointment, medical/vision or account information:

- Spouse: ____

- Adult Children: ____

- Parents / Caregivers: ____

- Health Care Physicians: ____

- Other: ____

Patient or Guardian signature: ________________________________Date: ______________

Relationship (If not signed by patient): ____

____

Internal Use Only

If patient / patient's representative refused to sign acknowledgment, please document the date and time notice was presented to patient and sign below.

Presented on (Date and Time) ______________________________By (Name and Title) ____

Patient Financial Responsibility

We are committed to providing you with the best possible vision care. If you have special needs, we are here to work with you. The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services.

1. The total patient balance due is required to be paid at the time services are provided. For your convenience, we accept cash, check, Visa, MasterCard, Discover, and Care Credit.
2. Our office participates with a variety of insurance plans. It is your responsibility to:
   - Bring your insurance card to every visit.
   - Be prepared to pay your co-payment and/or co-insurance to every visit.
   - For care not covered, deemed medically unnecessary, or cosmetic by your insurance company, payment in full is due at the time of visit.
3. If you have insurance that we do not participate in, our office is happy to give you a detailed receipt. However, payment in full is required at the time of service.
4. If the total patient balance due cannot be paid in full, arrangements must be made prior to service being rendered.
5. If the patient is a minor (18 years or younger), the parent or guardian must sign below. The parent, guardian or unaccompanied minor is responsible for any payment due at the time of service, bringing the necessary insurance card.
6. If you have any questions about your insurance, we are happy to help. Specific coverage issues, however, should be directed to your insurance company's member services department.

Drs Webb & Webb Optometrists firmly believes that a good physician/patient relationship is based upon understanding and good communications. Questions about financial arrangement should be asked prior to services provided.

Patient Signature: ___________________________________Date: ___________________