



Welcome to our office!

Reason for today's visit: _____

When was your last eye exam? _____

Which doctor are you scheduled to see? (please circle) Dr. Mackenzie Weir Dr. William Chafin

Patient Demographics

Please circle: Mr. Mrs. Ms. Miss Dr. Child (under 17) Male Female

First Name (Legal) MI Last Name Preferred Name

Mailing Address City State Zip Code

Cell Phone Home Phone Daytime Phone

E-Mail Address Date of Birth Social Security Number

Employer Occupation Status

(Full Time, Part Time, Not Employed, Student, Retired)

Marital Status: Single Married Divorced Widowed

Emergency Contact Information:

Name Relationship Phone

Whom do we thank for referring you to our office?

If not referred by a patient, how did you hear about our office?

Do we see any other family members?

Social History

Preferred language: English Spanish Other:

Race: (please circle) American Indian Alaska Native Asian Black or African American

 Hispanic Native Hawaiian or other Pacific Island White

Ethnicity: (please circle) Hispanic or Latino Native Hawaiian or other Pacific Island Non- Hispanic or Latino

Do you have any hobbies that require special glasses or contacts? _____

If we are filing insurance for you today, the following questions must be answered:

In order to file any insurance claims for you, we must copy ALL insurance cards and photo I.D. at the time of your visit.
(This includes medical, vision and prescription cards)

Guarantor (Account Responsibility) if patient is a minor:		
Full Legal Name (As it appears on Insurance Card)		Relationship to Patient
Daytime Phone Number	Social Security Number	Date of Birth
Vision Insurance Name: _____		
Medical Insurance Name: _____		
Prescription Insurance Name: _____		
Policy Holder: _____		Policy Holder's Date of Birth: _____
Policy Holder's Phone Number: _____		Policy Holder's Social Security Number: _____
Preferred Pharmacy: _____		

INSURANCE:

I hereby authorize payment of my vision, medical and surgical insurance benefits to Amarillo Family Eyecare. I agree/understand I am financially and fully responsible for payment and any charges, whether paid for or denied by said insurance. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Amarillo Family Eyecare on the date of service. I authorize Amarillo Family Eyecare to release any information required to process any and all claims for reimbursement on my behalf. A copy of the authorization may be used in place of the original.

Signature: _____

Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:

I have been presented with a copy of the Notice of Privacy Practices for Protected Health Information, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information. I acknowledge that I have reviewed and understand these policies provided to me by Amarillo Family Eyecare.

Print Name: _____

Signature: _____

Date: _____

I wish to allow the following disclosure of my health information:

1. _____
2. _____

MEDICAL HISTORY

Do you have allergies to medications? (circle) NO YES, if so, explain: _____

List any medications you take (including oral contraceptives, aspirin, over the counter and home remedies):

List any major injuries, surgeries and/or hospitalizations you have had: _____

Do you wear glasses? (circle) NO YES If so, how old are your present lens? _____

Do you wear contact lens? NO YES If so, how old are your present lens? _____

What brand are they? _____ Type: Rigid Soft Extended Wear Daily Wear

Are they comfortable? _____ How many hours can you wear them? _____

Are you pregnant and/or nursing? NO YES

Are you being treated for, or is there any family history of any of the following:

DISEASE/ CONDITION	YOU	NO	YES	FAMILY- includes parents, grandparents, siblings, children; living or deceased	NO	YES
Blindness						
Cataracts						
Crossed Eyes						
Glaucoma						
Macular Degeneration						
Arthritis						
Cancer						
Diabetes						
Heart Disease						
High Blood Pressure						
Kidney Disease						
Lupus						
Thyroid Disease						
Other:						

Social History

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

_____ No, I do not wish to discuss with my doctor.

_____ Yes, I wish to discuss with my doctor

Do you drive? (circle one) NO YES If so, do you have difficulty while driving? NO YES

Please describe:

Do you use tobacco products? NO YES If so, type/amount per day/how many years: _____

Do you drink alcohol? NO YES If so, type/amount per day/how many years: _____

Do you use illegal drugs? NO YES If so, type/amount per day/how many years: _____

Review of Systems – Do you currently, or have you ever had any problems in the following areas?

CONSTITUTIONAL	NO	YES	EARS, NOSE, THROAT	NO	YES
Fever, Weight gain/loss			Allergies/Hay Fever		
NEUROLOGICAL			Sinus Congestion		
Headaches			Runny Nose		
Migraines			Post- Nasal Drip		
Seizures			Chronic Cough		
EYES			Dry Mouth		
Loss of Vision			RESPIRATORY		
Blurred Vision			Chronic Bronchitis		
Distorted Vision/Halos			Emphysema		
Loss of Side Vision			VASCULAR/CARDIO		
Double Vision			Diabetes		
Dryness			Heart Pain		
Mucous Discharge			High Blood Pressure		
Redness			Vascular Disease		
Sandy or Gritty Feeling			GASTROINTESTINAL		
Itching			Diarrhea		
Burning			Constipation		
Foreign Body Sensation			GENITOURINARY		
Excess Tearing/Watering			Genitals/Kidney/Bladder		
Glare/Light Sensitivity			BONES/JOINTS/MUSCLES		
Eye Pain or Soreness			Rheumatoid Arthritis		
Chronic Infection			Muscle pain		
Sties or Chalazion			Joint Pain		
Flashes/Floaters			LYMPHATIC/HEMATOLOGIC		
Tired Eyes			Anemia		
ENDOCRINE			Bleeding Problems		
Thyroid/Other glands			PSYCHIATRIC: explain below		

If you answered yes to any of the above or have a condition not listed, please explain:



Financial Policy

As a courtesy to our patients, we will bill your insurance for services rendered in our office. All co-pays, deductibles, and estimated “out of pocket” expenses are due in full at the time of service. Please remember these are estimates based on the information your insurance company has provided to us and is *not* a guarantee of payment. Therefore, your out of pocket expense is subject to change after your insurance has paid their portion. All remaining balances are the responsibility of the patient or responsible party. You must provide the correct insurance information before or at the time of service, as we will not change the claim after it has been filed. Most insurance companies allow a minimum of 90 days to file a claim, and some up to 18 months. Any claims not paid by your insurance company within 90 days of us filing your claim will become the responsibility of the patient/guarantor. **It is your responsibility to ensure that we participate in your insurance company’s network. You should verify this information by contacting your insurance company or reviewing your provider list.**

Payment is due at the time services or products are provided. We accept cash, check, and major credit cards. For products and or services over \$200, we also accept CareCredit. CareCredit allows you to purchase products today and spread payments over 6 months. Applying for CareCredit only takes a few moments and there is no fee to apply. You may call, go online, or simply fill out a form in our office. Any staff member would be happy to assist you.

Please sign that you have read, understand and agree to these policies above.

Cash or Check

CareCredit

Major Credit Card/HSA

Please print patients name

Patient Signature (Patient’s Parent/Guardian if under 18)

Date