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

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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 What is your preferred pharmacy? ____________________________

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

DISEASE/ CONDITION	YES	NO	FAMILY- includes parents, grandparents, siblings, children; living or deceased	YES	NO
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? YES NO If so, type/amount per day/how many years: ______________________

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

Do you use illegal drugs? YES NO 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	YES	NO	EARS, NOSE, THROAT	YES	NO
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 if 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.

There will be NO REFUNDS on any purchases. This includes accessories, contact lenses, glasses, and services.
Contacts may be exchanged within a year of purchase with a 10% restocking fee.

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