PATIENT REGISTRATION & EYE/HEALTH HISTORY

NAME (Mr/Mrs/Ms) _____ TODAY'S DATE _____

ADDRESS _____ AGE _____ BIRTH DATE _____

CITY _____ STATE _____ ZIP _____ HOME PHONE _____

PARENT (if minor) or maiden name _____ WORK PHONE _____

EMAIL ADDRESS _____ CELL PHONE _____

OCCUPATION (GRADE IF STUDENT) _____ EMPLOYER (SCHOOL) _____

SSN# _____ HOBBIES/SPORTS _____

Who may we thank for referring you to our office? _____

REASON FOR TODAY'S VISIT? _____

VISION INSURANCE _____ HEALTH/ MEDICAL INSURANCE _____

LAST EYE EXAM _____ EYE DOCTOR/CLINIC _____

GENERAL PHYSICIAN/CLINIC _____ LAST PHYSICAL _____

MEDICATIONS YOU ARE TAKING _____

_____

DRUG ALLERGIES _____

Most insurance companies now require us to ask the following questions of patients 14 years of age and over. We apologize for the intrusion.

DO YOU:	YES	NO	DTA *(decline to answer)*
Smoke	_____	_____	_____
Drink Alcohol	_____	_____	_____
Have problems with Substance Abuse	_____	_____	_____

I prefer to be contacted via: ❑ Home Phone ❑ Cell Phone ❑ Work Phone ❑ Email ❑ Regular Mail

Preferred Language: _____English _____Spanish

Race: _____ African American _____ Caucasian _____ Hawaiian _____ American Indian
_____ Hispanic/Latino _____ Asian _____ Indian _____ Multiracial _____ Arab

Ethnicity: _____Hispanic/Latino _____Not Hispanic/Latino

Height_____ Weight_____

TODAY'S PROFESSIONAL FEES WILL BE PAID FOR BY: (Circle One)

CASH CHECK CREDIT CARD *(VISA MC, DISCOVER)* MEDICARE MEDICAID INSURANCE

Glasses or Contact Lenses must be paid in full before delivery

(OVER FOR INSURANCE INFORMATION)

PRIMARY INSURANCE

Name of Insurance Company: _____

Subscriber's Social Security Number: _____

Policy Number: _____ Group Number: _____

Subscriber's Name: _____ Subscriber Birth Date: _____

Subscriber's Employer: _____

SECONDARY INSURANCE

Name of Insurance Company: _____

Subscriber's Social Security Number: _____

Policy Number: _____ Group Number: _____

Subscriber's Name: _____ Subscriber Birth Date: _____

Subscriber's Employer: _____

— INSURANCE AUTHORIZATION —

INSURANCE COMPANY _____ ID# _____

I request that payment of authorized insurance benefits be made on my behalf to Rock Island Optometric/Mercer County Family Eyecare. I also authorize the release of any information necessary to process claims. I permit my signature to be kept on file for future claims. Any services not covered by insurance are understood to be my liability.

SIGNATURE _____ ***DATE:*** _____

ACKNOWLEDGMENT OF RECEIPT

I acknowledge that I received a copy of Rock Island Optometric Center's Notice of Privacy Practices.

Patient Name _____

Signature _____ Date _____