PATIENT INFORMATION

Patient's Full Name:_____Birthdate:_____

Address:_____City:_____State:____Zip:_____

Sex: ( )Male ( ) Female Do you prefer to receive calls at:____Home ____Work ____Cell

Phone Numbers: Home_____Work_____Cell_____

E-mail:_____(For notification only)

Employer:_____ Occupation_____

Spouse or parent's name_____Work phone #_____

Whom may we thank for referring you to us?_____

VISION INSURANCE INFORMATION

Name of Insured:_____Relationship to patient:_____

Primary Insurance:_____Policy Number:_____

Secondary Insurance:_____Policy Number:_____

Family Physician:_____Phone Number:_____

AGREEMENT TO PAY

In consideration of professional services rendered to the above patient, I/We agree to pay when billed customary charges for all services. I/We accept responsibility for payment of all services, which may be denied insurance coverage, due to exclusion from covered services, noncompliance with preauthorization requirements, or any other reason for denial. I hereby authorize payments to be made directly to Aileen W. Heaston, O.D. for any service furnished. I understand I am responsible to Aileen W. Heaston, O.D. for any payments made directly to me.

PATIENT SIGNATURE **OTHER RESPONSIBLE PARTY** **DATE**

AUTHORIZATION TO RELEASE MEDICAL INFORMATION AND ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I hereby authorize Aileen W. Heaston, O.D. to release medical or other information to the patient's insurance carrier and its designees and in workers' compensation cases, to the patient's employer needed to determine benefits. I acknowledge that Aileen W. Heaston, O.D. respects the legal obligation to keep health information that identifies the above patient private and have received the notice of privacy practices.

PATIENT SIGNATURE **OTHER RESPONSIBLE PARTY** **DATE**

DEMANDFORCE AGREEMENT: I agree to allow Demandforce to use this information in providing my services.

PATIENT SIGNATURE **OTHER RESPONSIBLE PARTY** **DATE**

HEALTH HISTORY

Reason for today's exam:_____ Date of last exam:_____

Do you currently wear glasses? ___Yes ___No

When do you wear your glasses?

___Full time ___Reading only ___Other_____

Do you wear contacts? ___Yes ___No

Are you interested in wearing contact lenses? ___Yes ___No

What hobbies or sports do you participate in?_____

Do you have any allergies?_____

Please list all medications you are currently taking/reason for taking them:

_____

_____

Do you or anyone in your immediate family have a history of the following? If so, who?

Diabetes_____ High blood pressure_____

Blindness_____ Turned or lazy eye_____

Cataracts_____ Macular Degeneration_____

Thyroid_____ Heart Condition_____

Glaucoma_____ Retinal Disease_____

Cancer_____ Dry Eye_____

Have you ever had any of the following conditions involving your eyes?

___Eye surgery ___Sensitivity to light ___Eye injury

___Eye infection or disease ___Floaters or spots ___Double vision

___Eyes burn/itch/water ___Eye strain ___Severe pain

X_____

SIGNATURE OF PATIENT (Or parent if a minor) DATE