CLEAR VIEW EYE CLINIC

DATE

PATIENT INFORMATION	PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT/INSURANCE MEMBER (must be 18 or older)
Name_____	□ **Same as Patient** (then skip to INSURANCE INFO)
Birthdate_____/_____/_____	Name_____
Address_____	Birthdate_____/_____/_____
_____	Address_____
City_____State___ Zip_____	_____
Telephone_____□home □cell □work	City_____State___ Zip_____
E-Mail_____	Telephone_____□home □cell □work
Social Security #(for billing purposes)_____	E-Mail_____
Are You: □ Employed (By):_____ □ Retired □ Unemployed □ Student	Social Security #(for billing purposes)_____
□ Male □Female	Are You: □ Employed By:_____ □ Retired □ Unemployed □ Student
Preferred Language: □English □Other_____	**INSURANCE INFO:** (alternatively, you may furnish a copy of your insurance card(s))
Ethnicity: □White □Hispanic □Asian □Black □Other	Company_____ Policy#_____ Group #_____

• **WHAT IS THE REASON FOR YOUR VISIT TODAY?**_____

_____

• **If Referred**: □TV □Radio □Newspaper □Physician □Current Patient_____ □Other_____

• **Primary Doctor** (Name and Practice Location)_____ • **Previous Eye Doctor**_____

• **I Wear**: □Glasses (current pair is____year(s) old) □Contacts (brand/lens_____ solution_____)

• **Visual Activities I participate in**: ☐Shooting ☐Skiing ☐Running ☐Golf ☐Tennis ☐Biking ☐Other_____

CLEAR VIEW EYE CLINIC, INC INSURANCE AND PAYMENT POLICY

As a courtesy to you , our clinic will submit claims to your insurance company for you. However, we cannot accept liability for collecting your claim because the policy is a contract between you and your insurance company.

I agree to furnish the appropriate insurance information to the Clear View Eye Clinic, Inc so that they may submit charges to my insurance company. If I do not have this information I understand that I am responsible for the charges in full on the date of service.

I hereby authorize benefits, which I am entitled, to be paid to Clear View Eye Clinic, Inc. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges incurred including services not paid by my insurance if I have insurance. Any portion of the claim not covered within 30 days will be my responsibility. A FINANCE CHARGE of 1% will be incurred monthly on all accounts with a balance over 30 days old. I understand that after 30days Clear View Eye Clinic, Inc will continue to help collect my benefits from my insurance company.

INSURANCE REQUIRES THAT CO-PAYMENTS AND OVERAGES ARE DUE AT THE TIME OF SERVICE

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct healthcare operations involving our office. The ***Notice of Privacy Practices*** you have been given describes these uses and disclosures in detail.

Signed_____Date_____

Although optometric personnel primarily treat the area in and around the eyes, your eyes are a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the eyecare you will receive. Thank you for answering the following questions.

• **LIST ALL MAJOR HOSPITALIZATIONS, INJURIES, and SURGERIES**_____

• **MEDICATIONS** (include over-the-counter and supplements):_____

• **ALLERGIES**:_____

□ALL NEG	**Allergic/Immunologic**
□	Drug Allergies
□	Environmental Allergies
□	Rheumatoid Arthritis
□	Lupus
□	Other_____

□ALL NEG	**Eyes**	
□	Glaucoma	□ Itching
□	Cataracts	□ Redness
□	Double Vision	□ Tired Eyes
□	Surgery	
□	Macular Degeneration	
□	Retinal Disease	
□	Dryness/Burning	
□	Pain/Soreness	
□	Infection/Discharge	
□	Loss of Vision or Side Vision	
□	Other_____	

□ALL NEG	**Muscle/Joint/Bones**
□	Fibromyalgia
□	Muscular Dystrophy
□	Osteoarthritis
□	Ankyosing Spondylitis
□	Other_____

□ALL NEG	**Cardiovascular**
□	Heart Disease
□	High Blood Pressure
□	Stroke
□	Vascular Disease
□	Other_____

□ALL NEG	**Gastrointestinal**
□	Chrohn's Disease
□	Colitis
□	Rheumatoid Arthritis
□	Ulcer
□	Digestive Trouble
□	Other_____

□ALL NEG	**Neurological**
□	Multiple Sclerosis
□	Epilepsy/Seizures
□	Alzheimer's Disease
□	Parkinson's Disease
□	Migraines
□	Other_____

□ALL NEG	**Constitutional**
□	Developmental Disability
□	Weight Loss
□	Fever
□	Fatigue
□	Trauma
□	Other_____

□ALL NEG	**Genitourinary**
□	Current STD
□	UTI
□	Other_____

□ALL NEG	**Psychiatric**
□	Depression
□	Panic Disorder
□	Schizophrenia
□	Other_____

□ALL NEG	**Ears/Nose/Mouth/Throat**
□	Upper Resp. Tract Infection
□	Ear Ache
□	Sore/Dry Mouth/Throat
□	Ringing/Tinitis
□	Other_____

□ALL NEG	**Hematologic/Lymphatic**
□	Anemia
□	Large Blood Volume Loss
□	Bleeding Disorder
□	Leukemia
□	Other_____

□ALL NEG	**Respiratory**
□	Asthma
□	Bronchitis
□	Emphysema
□	Tobacco Use
□	Other_____

□ALL NEG	**Endocrine**
□	Non-Insulin Diabetes
□	Insulin Dependent Diabetes
□	Thyroid Dysfunction
□	Hormonal Dysfunction
□	Other_____

□ALL NEG	**Integumentary**
□	Eczema
□	Rosacea
□	Psoriasis
□	Other_____

If you answered YES to any of the above or have a condition not listed, please explain and list any medications related to that condition:_____ _____

_____

_____

• Do you use tobacco products, drink alcohol, or use illegal drugs? □**Yes** □**No** (if yes, please explain)_____

• Have you ever been exposed to or infected with gonorrhea, hepatitis, HIV, or syphilis?_____

• Do you drive? □**Yes** □**No** • Do you have trouble seeing when driving, especially at night? □**Yes** □**No**

• Do you have trouble seeing to read, watch television, walk or perform other daily activities? □**Yes** □**No**

• **WOMEN**: Are You: Pregnant/Trying to get Pregnant? □**Yes** □**No** Taking Contraception/Birth Control? □**Yes** □**No** Nursing? □**Yes** □**No**

FAMILY HISTORY

Condition		Relationship to you	Condition		Relationship to you
Blindness	□**Yes** □**No**		Cancer	□**Yes** □**No**	
Cataract	□**Yes** □**No**		Diabetes	□**Yes** □**No**	
Crossed/Lazy Eye	□**Yes** □**No**		Heart Disease	□**Yes** □**No**	
Glaucoma	□**Yes** □**No**		High Blood Pressure	□**Yes** □**No**	
Keratoconus	□**Yes** □**No**		Kidney Deisease	□**Yes** □**No**	
Macular Degeneration	□**Yes** □**No**		Lupus	□**Yes** □**No**	
Retinal Detachment	□**Yes** □**No**		Thyroid Disease	□**Yes** □**No**	
Retinal Disease	□**Yes** □**No**		Other_____	□**Yes** □**No**	

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform Clear View Eye Clinc of any changes in medical status

Signature of Patient, Parent, or Guardian_____ Date_____

WELCOME TO THE CLINIC AND THANK YOU FOR CHOOSING US FOR YOUR EYECARE