North County Eye Center

Please print and complete all information

Patient Information

Name: ____ **Home #**_____________ **Cell #**_______________

Address: ____ **City:** __________ **State:** ____ **Zip:**________

Drivers Lic # ___________________ **Date of Birth:** _____________ **Sex:** ____ **SSN:** ____________________

Employer: __________________ **Occupation:** _______________ **Email:** ________________________________

Primary Care Physician: ___________________________________ **Marital Status:** _______________________

*** Race (Please check one):** ___ American Indian or Native Alaskan ___ Asian ___ Black or African American ___Hispanic ___ Native Hawaiian/Other Pacific Islander ___ White *Preferred Language __________________

***Ethnicity:** __ Hispanic or Latino __ Native Hawaiian/Other Pacific Islanders __ Not Hispanic or Latino

Insurance Information **(please present card to receptionist)**

Primary: Insurance name: ____________________________________ **Insurance ID#:** ___________________

Primary insured's name: ________________________________ **Primary insured's date of birth:** ___________

Secondary: Insurance name: __________________________________ **Insurance ID#:** ___________________

Secondary insured's name: ____________________________ **Secondary insured's date of birth:** __________

Vision Plan: Insurance name: ______________________ **Insured's Social Security Number:** _____________

Insured's name: ____ **Insured's date of birth:** __________

Office Policy

*Please remember that payment is your responsibility regardless of insurance. Those patients with health plans requiring referrals are responsible for providing these referrals for each visit. All co-pays are due at the time of the visit.

*Authorization to release information for insurance purposes: I hereby authorize my physician to release any information acquired in the course of my examination or treatment.

I have read and understand the above statement. I agree to comply with the financial policies of this office.

Patient's Signature: ____ Date: _______________

Or Legal Guardian: ____ Relationship: ________________

North County Eye Center

Refractions and Other Non-Covered Charges

Refraction is the procedure in which we determine the best corrected visual acuity of each eye for the purposes of medical evaluation or for prescribing glasses or corrective surgery. The Medicare guidelines specifically exclude this service and the majority of commercial insurance companies follow Medicare guidelines.

North County Eye Center must inform you in advance of any medical services that may not be covered by your insurance. As a courtesy to you, the patient, we will bill your insurance company. However, it is your responsibility to know your policy benefits and limitations.

I further request and authorize that payment of authorized Medicare and/or commercial insurance medical benefits be made on my behalf to North County Eye Center, Inc. for professional services rendered. I understand that this may not represent the full payment for services rendered and I will be responsible for the balance due.

I permit a copy of this authorization to be used in place of the original and authorize any holder of medical information about me to release to the Social Security Administration or Health Care Financing Administration or agents, any information needed to determine these benefits or the benefits payable for related services.

Patient's Signature: ______________________________ Date: ______________

Or Legal Guardian: ______________________________ Relationship: ______________

Privacy Policy

-Acknowledgement of Receipt of Notice or Privacy Practices and Confidential Channel Communication Request and have received a copy of this medical practice's notice of Privacy Practices upon request.

We may need to contact you for the following:

Reminder calls, test results, setting appointments and rescheduling appointments

________ I want to be contacted by phone with test results. It is okay to leave messages on my answering machine or with another person at the phone number given.

________ I do not want to be called. Mail my results to my home address.

________ Please e-mail me my results. *e-mail address______________________________

**Please tell us if you do NOT want our automated phone system to call you to remind you of future appointments.*

Signed: ______________________________ Date: ______________

Printed Name: ______________________________ Relationship: ______________

Emergency Information **(nearest friend or relative not living with you)**

Name:______________________________ **Home #** ______________ **Work #** ______________

Name: ______________________________ **Age:** ___ **Sex:** ___ **Date**: ____________

Reason for Visit: ______________________________

Medical History: *Do you currently have?* (Please check all that apply)

High Blood Pressure
Diabetes – Type ______
COPD/Emphysema/ Asthma
Heart Disease
High Cholesterol
Lung Disease
GERD/Reflux
Liver Disease
Mitral Valve Prolepses
Allergy/Hay fever
Gout
Thyroid Disease
Kidney Disease
Arthritis
Other: ______________
Osteoporosis
Cancer
Depression
Fibromyalgia

Past Surgical History: (Please specify the type of surgery)

____________ ____________ ____________
____________ ____________ ☐ **No Past Surgical History**

Current Systematic Medication(s):

____________ ____________ ____________ ____________
____________ ____________ ____________ ____________

Drug Allergies: ____________ Reaction to Allergies: ____________
No Known Drug Allergies

Eye History: (Please check all that apply to you.)

Past Eye Surgeries: ______________________________

Glaucoma
Trauma
Cataract
Macular Degeneration
Retinal Detachment
Lasik
Dry Eye
Contact lens wear

Visual/Ocular Symptoms: (Please check all that apply to you)

______ Light Sensitivity
______ Dryness
______ Eye pain or soreness
______ Mucous Discharge
______ Floaters or Spots/Flashes of light
______ Itching
______ Excessive Tearing/Watering
______ Loss of vision
______ Redness
______ Distorted vision (halos)/Glare
______ Blurred Vision
______ Foreign Body Sensation
______ Headaches

Current Ocular Medication(s) (drops): (including over the counter)

____________ ____________ ____________
____________ ____________ ____________

Drug Allergies: ____________ Reaction to Allergies: ____________
No Known Allergies

Family History and Relation: (Please check if yes. Please specify father/mother etc., if applicable, on the line provided)

Glaucoma ________ Retinal ________ Blindness________ None Apply

Social History: (Please check if yes and answer to the best of your knowledge)

Tobacco	Currently use Never used	Packs per Day? _____	Former user	I quit ___ years ago.
Narcotics	Currently use Never used	Type: ________	Former user	I quit ____ years ago.
Alcohol	Currently use Never used	Frequency? ______	Former user	I quit ____ years ago.
HIV Positive - CD 4 Count? ________			Sexually Transmitted Diseases(STDs)	Type(s):________

Blood Transfusion

Birth Order? of you and your siblings, you are:
(circle one) 1st 2nd 3rd 4th 5th or more

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