Patient Info Update

Today's Date: _____/_____/_____

Name: _____ Date of Birth: _____/_____/_____

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ Cell Number: _____

Email: _____

Preferred Communication: (please circle) Call Text Email

Insurance Information:

Medical Insurance: _____ ID/SSN: _____

Subscriber Name: _____ Date of Birth: _____/_____/_____

Vision Plan: **VSP EYEMED DAVIS Other_____ None** ID/SSN: _____

Subscriber Name: _____ Date of Birth: _____/_____/_____

Medical/Vision History Update (Check All That Apply)

Glare at night		Eye Surgery		Stroke	
Double Vision		Eye Infection		Headaches	
Blurred vision		Eye injury		Migraines	
Droopy lids		Diabetes		Multiple Sclerosis	
Watery eyes		High Blood Pressure		Cancer	
Vision loss		High Cholesterol		Mental illness	
Glaucoma					

Any additional Conditions not listed above?

Are there any other vision concerns or options that you would like to discuss with the doctor?

Are you taking any medications? Please list them.

Are you allergic to anything? Yes No. If yes, what?

If you would like to schedule your next annual eye exam today and get $10 off that visit please let us know

For Contact lens patients:

Is there anything you would like to improve about your contacts?

Please review and sign:

Contact lens evaluation and fit are not covered by most insurance companies. This is a yearly fee to renew your contact lens prescription that includes: corneal curvature, proper fitting, recommendations for solutions & wearing schedule, and any needed trials/follow visits. The cost for an evaluation and fit is usually $40-75. Please sign for acknowledgement of this fee:

Signature_____

Acknowledgment of Privacy Notice

By signing this acknowledgment of Notice of Privacy Practices, I acknowledge that I have read and understood the Notice of Privacy Practices of Eye Care Solutions and have the right to receive a copy for review and to keep for my records on the date identified below.

I understand that Eye Care Solutions may use and disclose necessary personal health information (for example, my name, address, insurance subscriber identification numbers, eye exam information and/or type of products provided) to another party to permit Eye Care Solutions to perform administrative duties, provide me with eye care services, and products, process my insurance claims, and communicate with me regarding vision care services provided by our office. This could also include mailings and/or phone calls of exam reminders or information about services and/or products provided by Eye Care Solutions.

I can be assured that Eye Care Solutions does not sell my personal health information of any kind to a third party for such party's own use. I authorize Eye Care Solutions to submit my vision benefit claims to my plan sponsor or health plan, to receive reimbursement for the vision services and products that I have received.

_____ _____

Signature of Patient or Patient's Legal Representative (must be 18 or older) Date