PATIENT REGISTRATION AND HEALTH HISTORY

Please Print In Black Ink Only

First Name_____ MI_____ Last Name_____
Preferred Name_____Date of Birth_____ ___Male ___Female
Mailing Address_____ Physical Address_____
City_____State_____Zip Code_____ Hobbies_____
Telephone (H)_____(W)_____(C)_____
Employer_____ Occupation _____
Guardian/Emergency Contact_____
(Name) (Telephone Number)

What is the main reason for your visit today?_____

Patient Visual Symptoms

(check all that apply to you)

___Distance Vision Blur ___Near Vision Blur ___Dry Eyes ___Itchy Eyes
___Double Vision ___Eye Pain ___Eyestrain ___None, Routine Exam
___Other_____

Patient Health History

(check if you have had health problems with any of these systems)

___Eyes ___Gastrointestinal ___Nervous ___Ear/Nose/Throat
___Genitourinary ___Endocrine (glands) ___Cardiovascular ___Muscular-skeletal
___Blood/lymph ___Respiratory ___Skin ___Immune
___Other_____

(check the diseases that apply to you)

___Diabetes ___High blood pressure ___Thyroid Condition ___Allergies
___Asthma ___High Cholesterol ___Psychiatric Disorders ___Seizures
___Glaucoma ___Cataracts ___Macular Degeneration ___Crossed Eye
___Other_____

Family Health History

(check the diseases that apply to anyone in your immediate family)

___Diabetes ___High blood pressure ___Thyroid Condition ___Allergies
___Asthma ___Psychiatric Disorders ___Seizures ___Crossed Eye
___Glaucoma ___Cataracts ___Macular Degeneration ___Retinal Detachment
___Other_____

Are you currently taking any medications? ___Yes___No If yes, please list_____
Are you allergic to any medications? ___Yes___No If yes, please list_____
Name of medical doctor_____ Date of last visit_____
Have you had any eye operations? ___Yes___No If yes, please list_____Date_____
Have you had any eye injury? ___Yes___No If yes, please list_____Date_____
Do you wear glasses? ___Yes___No Do you wear contact lenses? ___Yes___No
Do you smoke?___Yes ___No Have you ever smoked? ___Yes ___No Smokeless tobacco?___Yes___No
Do you use alcohol?___Yes___No How many drinks per week?____ Do you use illicit drugs?___Yes___No

Approximately how long ago was your last eye examination?_____

Signature X_____ Date_____

Print Name _____ Relationship To Patient_____

Owl Creek Vision Care

Financial Policy

Payment at the time of service by cash, check or credit card is expected. Any amount outstanding over 30 days is subject to a finance charge of 1.58% per month (19% annual rate). A discount of 5% will be given to those who pay in full at the time of service. Discounts are not applicable for those with outstanding balances. Prior to ordering optical materials, fifty percent of the total fee is required. A fee will be assessed for missed appointments without 48 hours notice.

Insurance
As a courtesy to our patients, we can process your primary insurance. We accept assignment from most major insurance carriers, however we do not participate in all insurance programs. If your insurance company is not one with which we participate, we will assist you in completing your insurance form after you pay for all materials and services rendered. Please provide our office with your insurance card and any information contained in your insurance manual at the time of your visit. With this information we can better serve you by estimating your portion of the bill at the time of service. Many insurance companies require prior authorization and cannot be billed after the date of service. Since final coverage for any materials or services cannot be guaranteed, payment of the full fee is required in order for us to provide a discount for payment at the time of service. **Remember, the patient has full responsibility for payment. The insurance company carries no liability for payment.**

Insurance Information

Patient's Name_____ Subscriber's Name _____

Subscriber's Date of Birth_____ Subscriber's Relationship to Patient _____

Insurance Carrier Name _____ Insurance Carrier Address _____

Employer's Name _____ Policy Number _____Effective Date_____

Employer's Address _____ Employer's Phone _____
_____ Contact Person _____

I understand the financial policy of this office. I agree to pay for all materials and services that are not covered by insurance. I also authorize the release of any medical or other information necessary to process this claim.

Patient Signature_____Date_____

Print Name_____