NEW PATIENT QUESTIONNAIRE **DATE**: _______/_______/_______

NAME ______________________________ **DATE OF BIRTH** ____/_____/_____ **BIRTH SEX**: M F

HOME ADDRESS ________________________________ **CITY** __________________ **STATE** ________

ZIP CODE __________ **HOME/CELL PHONE** _________________ **WORK PHONE** _________________

EMAIL ____ **(MCARE / VSP, FULL SSN NEEDED)**

MARITAL STATUS MARRIED SINGLE OTHER________________**SSN/L4**________________________

PRIMARY CARDHOLDER (PAYMENT & INSURANCE) __________________________**DOB** ____/___/____

PRIMARY CARDHOLDER SSN (IF VSP)______________________

NOTE: THIS OFFICE DOES NOT SEND BILLS FOR PROFESSIONAL SERVICES - ALL COPAYS DUE AT TIME OF SERVICE

HOUSEHOLD MEMBERS

Name	Ages	Date of Last Dilated Eye Exams
Spouse:		
Parents:		
Children:		

I have received, read, reviewed, and accept the "Acceptance of Payment Responsibility" and "HIPAA authorization" forms:

Signature of Patient ______________________________ Date ____/____/____

Signature of Guardian ______________________________ Date ____/____/____

Medical History (Your History Left, Family History Right):

Condition	YOU	FAM	Condition	YOU	FAM	Condition	YOU	FAM
NONE								
Anxiety			Depression			Hyperthyroid		
Arthritis			Diabetes			Hypothyroid		
Atrial Fibrillation			End Stage Renal Disease			Leukemia		
Bone Marrow Transplant			GERD			Lung Cancer		
BPH			Hearing Loss			Lymphoma		
Breast Cancer			Hepatitis			Prostate Cancer		
Colon Cancer			High Blood Pressure			Radiation Treatment		
COPD			HIV/AIDS			Seizures		
Coronary Artery Disease			Hypercholesterolemia			Stroke		
						Other ___________________		

Ocular History (Include R or L Eye or B for Both Affected)

Condition	YOU	FAM	Condition	YOU	FAM	Condition	YOU	FAM
NONE								
Cataracts			Macular Degeneration			"Lazy Eye"		
Diabetic Retinopathy			Epiretinal Membrane			Vitreous Detachment		
Dry Eyes			"High Eye Pressures"			Floaters		
Glaucoma			Ocular Migraine					
						Other ___________________		

List Any Medications Below:

List Any Allergies Below:

List Any Eye Surgeries Below:

Social History (Please Circle):

Smoker? Never Former Current

Alcohol Use: No Yes Amount Weekly:______

Pregnant or Nursing? Yes No

Illicit Drug Use? No Yes

Preferred Pronoun:

Acceptance of Payment Responsibility

Examination fee is due at the time of service. All contact lenses must be paid in full before ordered. Any co-payments are due at the time of service.

If you have insurance coverage for these services or materials, we will submit claims for you. However, we are not liable for collecting your claim. After 30 days, we will expect payment in full if your insurance company has not paid.

Returned NSF checks will be charged a service fee of $25.00.

I HEREBY AUTHORIZE MY INSURANCE CARRIER TO MAKE PAYMENT DIRECTLY TO **WEST SIDE PREVENTATIVE EYECARE** FOR ANY AND ALL SERVICES RENDERED TO ME BY WEST SIDE PREVENTATIVE EYECARE. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT COVERED BY INSURANCE.

I understand that choosing to purchase frames and lenses elsewhere and having the prescription checked again will incur a fee of $39.99. This fee is not waived unless it is determined that the prescription was outside of reasonable standards. Changes caused by medical reasons (including but not limited to Cataracts and Diabetes) may be subject to a refraction fee as well.

I also release any information regarding my treatment or condition in order to obtain payment for his professional services.

THIS OFFICE DOES NOT BILL FOR PROFESSIONAL SERVICES.

NO REFUNDS CAN BE ADMINISTERED AFTER A SPECTACLE ORDER, (OPENED/MARKED/DAMAGED) SOFT CONTACT LENSES, OR RIGID GAS PERMEABLE CONTACT LENS ORDERS ARE PLACED.

I HAVE READ AND AGREE TO THE PAYMENT POLICY STATED ABOVE.

IF APPLICABLE, I WILL BE PAYING TODAY BY (Circle): CASH ______ CHECK _____ CREDIT CARD _____

Signature of Patient ______________________________ Date ____/____/____

Signature of Guardian ______________________________ Date ____/____/____

HIPAA AUTHORIZATION FORM

Patient's Full Name ________________________________ DOB ____/____/_____

SS#XXX-XX-__________

I hereby authorize the use or disclosure of protected health information about me as described below.

1. I authorize West Side Preventative EyeCare to use or disclose my medical records to parties necessary for treatment and monitoring of my health, ocular and systemic.

2. **(Optional)** The following person (or class of persons) may receive disclosure of protected health information about me:

Name _________________________________

Address _________________________________

City ____________ State _______ Zip Code ________________

3. This agreement allows disclosure of my medical records for the lifetime of the contract as agreed upon below.

4. I understand that the information used or disclosed may be subject to re-disclosure by West Side Preventative EyeCare or facility receiving it, and would then no longer be protected by federal privacy regulations.

5. I may revoke this authorization by notifying West Side Preventative EyeCare in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

6. I understand my medical records will be kept private unless shared for completion and continuation of care for the above.

7. This authorization expires upon written notification of request for revocation.

FEES FOR COPIES: Federal and state laws permit a fee to be charged for the copying of patient records. You will be required to pre-pay for the copies.

Signature of Patient _____________________________ Date ____/____/____

Signature of Guardian _____________________________ Date ____/____/____