EYE & VISION CLINICS, SC

Date:_____

Last Name:_____ **First Name:**_____
MI:_____

Preferred Name/Nickname:_____ **Maiden Name:**_____

Date of Birth:_____ **Social Security Number:**_____

Address:_____

_____

Telephone: _____ (Home) □ preferred

_____ (Work) □ preferred

_____ (Cell) □ preferred

Email:_____

Marital Status:_____ **Spouse's Name:**_____

Children's Names/Ages:_____
_

Insured Name:_____ **Insured DOB:**_____ **Insured Employer:**_____

Patient Employer:_____ **Patient Occupation:**_____

(For Children) School:_____ **Grade:**_____

Parent/Guardian:_____
_____

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino □ Declined

Race: □ American Indian or Alaska Native □ Asian □ Black or African American
□Native Hawaiian or Other Pacific Islander □ White □ Other □ Declined

How did you find out about our office?

□ Friend/Relative/Coworker (Name_____)

□ Health Care Provider □ Insurance □ Website □ Other_____

Date of last eye exam_____ **Clinic Name/Location**_____

OVER →

Have you ever been diagnosed with any of the following conditions?

□ Cataract □ Age related macular degeneration □ Glaucoma □ Diabetes □ Diabetic Retinopathy

□ Dry Eye □ Eye infection, inflammation, or allergy □ Floaters/Flashes of light □ Iritis or Uveitis

□ Retina defects or degeneration □ Other_____

EYE & VISION CLINICS, SC

DAVID R. DUFECK, O.D. MATTHEW L. NELSON, O.D.

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CONSENT FOR SERVICES

I consent to evaluation and treatment services provided to me by Eye & Vision Clinics. I understand that
I may need additional testing, treatment, and visits if directed. I understand that it is my responsibility to schedule and keep future appointments and to follow instructions given to me by my doctor.

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have (received/been offered) a copy of the Notice of Privacy Practices for Eye & Vision Clinics, SC. This notice describes how this office may use and disclose my protected health information, and rights I may have regarding my protected health information.

PAYMENT AGREEMENT

I understand that I must provide accurate insurance information at each appointment in order for Eye & Vision Clinics to file a claim on my behalf. I authorize insurance payments directly to my provider for services provided. I understand that I am responsible for the full payment if the services are not covered by my insurance, I do not have insurance coverage, or my provider is not contracted with my insurance. I agree that I am responsible for copayments and charges placed towards the deductible, as well as any balance due after insurance payment is received. I will pay any outstanding balances upon receipt of a statement. I also understand that for any glasses or contact lens orders, payment must be made in full before the orders will be dispensed.

Signature **X** ____ Date_________________