

EYE & VISION CLINICS, SC – PATIENT INFORMATION

Date: _____

Last Name: _____ First Name: _____ MI: _____

Preferred Name/Nickname: _____ Date of Birth: _____

Social Security Number (last 4 digits): _____

Address: _____

Telephone: (Home) _____ preferred

(Work) _____ preferred

(Cell) _____ preferred

Email: _____

Marital Status: _____ Spouse's Name: _____

Patient Employer: _____ Patient Occupation: _____

*Insured Name: _____ *Insured Date of Birth: _____ Insured Employer: _____

Minor Children's Names/Ages: _____

(For Children) School: _____ Grade: _____

(For Children) 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 _____

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 _____

OVER →

EYE & VISION CLINICS, SC

DAVID DUFECK, O.D.

MATTHEW NELSON, O.D.

TYLER MAZUR, 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 _____ Date _____