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__________________