

**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 \_\_\_\_\_