PATIENT INFORMATION RECORD
(PLEASE PRINT) (Must be updated each year)

TODAY'S DATE_____ **METHOD OF PAYMENT: CASH** ◯ **CHECK** ◯ **CREDIT CARD** ◯

MR. ◯ **MRS.** ◯ **MISS** ◯ **MS.** ◯ **DR.** ◯ **PATIENT'S NAME** _____

ADDRESS_____ **CITY**_____ **ST**_____ **ZIP**_____

PHONE # _____ **Ext.** _____
(home) (work) (pager/cell)

SOCIAL SECURITY # _____ **MALE** ◯ **FEMALE** ◯ **DATE OF BIRTH** _____

PATIENT STATUS: **Married** ◯ **Single** ◯ **Widow** ◯ **Divorced** ◯ **Other** ◯ **Employed** ◯ **Student** ◯ **Retired** ◯

EMPLOYER/SCHOOL NAME: _____ **Occupation**_____
(name) (address)

HOW DID YOU HAPPEN TO COME TO THIS OFFICE? (CHECK ALL THAT APPLY) **Yellow Pages** ☐ **A Doctor** ☐

Saw our Sign ☐ **Insurance List** ☐ **A Friend/Relative (name)**_____ **Other**_____

PATIENT MEDICAL INFORMATION

WHAT EYE PROBLEMS ARE YOU HAVING?

WHEN WAS YOUR LAST EYE EXAMINATION? _____ **PREVIOUS EYE DOCTOR?** _____
DO YOU NOW OR HAVE YOU EVER WORN ☐**GLASSES** ☐**CONTACT LENSES**
ARE YOU INTERESTED IN CONTACT LENSES TODAY? ◯**YES** ◯**NO**
Please check box if applicable & provide details.

1. PAST EYE HISTORY: **EXPLANATION: (WHEN?)**

☐**INJURY** ☐**TUMOR** ☐**SURGERY** ☐**CROSSED EYE** _____
☐**DISEASE** ☐**AMBLYOPIA(LAZY EYE)** ☐**DRY EYES** _____
☐**CATARACTS** ☐**RETINA PROB.** ☐**GLAUCOMA** _____
☐**NO PREVIOUS INJURY/DISEASE** ☐**OTHER** _____

2. LIST ALL MEDICATIONS AND VITAMINS YOU ARE TAKING

3. ARE YOU ALLERGIC TO ANY MEDICATIONS? ◯**YES** ◯**NO**
IF YES, WHICH ONES/WHAT HAPPENS? _____
PRIMARY CARE PHYSICIAN: _____ **Date of last visit**_____

4. YOUR PAST MEDICAL HISTORY: (Check box if applicable & provide details.) **EXPLANATION: (WHEN?)**

☐**DIABETES** ☐**SURGERY** ☐**BACK/NECK DISORDERS** _____
☐**ENDOCRINE (GLANDS)** ☐**NEUROLOGICAL DISORDERS** _____
☐**STROKE** ☐**CANCER** ☐**RESPIRATORY DISORDERS** _____
☐**HIGH BLOOD PRESSURE** ☐**VASCULAR DISORDER** _____
☐**HEART DISORDERS** ☐**EMOTIONAL DISORDERS** _____
☐**URINARY DISORDERS** ☐**ARTHRITIS** _____
☐**THYROID CONDITION** ☐**HIGH CHOLESTEROL** _____
☐**ALLERGIES** ☐**OTHER** _____
☐**USE OF NICOTINE** ☐**USE OF ALCOHOL** ☐**OTHER DRUGS**

RATE YOUR GENERAL HEALTH: _____

5. YOUR FAMILY EYE HISTORY: (Check box if applicable & provide details.) **EXPLANATION: (MOTHER, FATHER, ETC.)**

☐**GLAUCOMA** ☐**DIABETES** ☐**CROSSED EYE** _____
☐**EYE CANCER** ☐**CATARACT** ☐**RETINA PROBLEMS** _____
☐**HIGH BLOOD PRESSURE** ☐**OTHER** _____

PLEASE COMPLETE INFORMATION ON BACK SIDE OF FORM

WHO IS RESPONSIBLE FOR THE PATIENT DUE BALANCE?

(REQUIRED IF PATIENT IS UNDER 18 YEARS OF AGE OR SOMEONE OTHER THAN THE PATIENT IS RESPONSIBLE)

NAME: _____ **RELATIONSHIP TO PT:**_____
(First) (MI) (Last)
ADDRESS: _____ **SSN:**
HOME PH: _____ **DOB:** _____
EMPLOYER NAME: _____ **EMPLOYER ADDRESS:** _____
OCCUPATION: _____ **WORK PHONE:** _____

PATIENT INSURANCE INFORMATION

MEDICARE ○ **TRICARE** ○ **MEDICAID** ○ **OTHER** ○

INSURANCE COMPANY NAME: _____

INSURED NAME: _____ **INSURED D.O.B.** _____ **RELATIONSHIP TO PATIENT** _____

EMPLOYER_____
(name) (address)
POLICY # _____ **GROUP#** _____

OTHER MEDICAL INSURANCE COVERAGE:

NAME_____**POLICY #**_____**SUBSCRIBERS NAME**_____

PATIENT'S/INSURANCE AUTHORIZATION AND ASSIGNMENT

I authorize Drs. Handeland, Batac and Seim to furnish information to insurance carriers including Social Security Administration or its intermediaries of carrier, concerning my illness and treatment. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to the party that accepts assignment. I understand that my insurance is a contract between me and my insurance carrier. I UNDERSTAND THAT I AM RESPONSIBLE FOR THIS ACCOUNT. I understand that if Drs. Handeland, Batac and Seim do not receive a response from my insurance company within 60 days of filing my claim, I am responsible for payment of this account in full. I understand that I am responsible for any amount not covered by insurance. I understand and agree to pay a finance charge of 1.5% per month (18% per year) on outstanding patient due balances over 30 days old. In the event of default on any payment due, I agree to pay all costs of collection, including attorney fees of 38 1/3% on the amount due at time of default. In the event that my check is returned for non-sufficient funds, I agree to pay a $25.00 fee.

X _____
(DATE) (PATIENT/GUARANTOR) (RELATIONSHIP TO PATIENT)

PATIENT RESPONSIBILITY UNDER MEDICARE

I have been informed that Medicare may not pay for my examination or optical aids, and will not pay for refraction. I understand that all charges submitted to Medicare, by Drs. Handeland, Batac or Seim, on my behalf, are and remain my responsibility. Should Medicare reject, deny or apply any payments towards my deductible, I will pay any remaining balance to Drs. Handeland, Batac or Seim, upon notification of amounts due.

X _____
(DATE) (PATIENT/GUARANTOR) (RELATIONSHIP TO PATIENT)

Deluxe Frames

I have chosen to purchase a deluxe frame (as described by Medicare) and will pay to Drs. Handeland, Batac or Seim any amounts not covered by Medicare to the frames.

X _____
(DATE) (PATIENT/GUARANTOR) (RELATIONSHIP TO PATIENT)