Personal Information

Date________/________/________ Preferred Name __________________________

Title _____First Name __________________________MI_______ Last Name ______________________________

Birth Date____/____/________ Gender ___________________ SSN# ______________________

Street Address________________________________City_________________State______Zip ______________

Home Phone (_____)_____-_______ Cell (_____)_____-_______ Work (_____)_____-_______

Email address___________________________Preferred contact Method: Home Phone / Cell Phone / Email

Marital Status_______________Employer_________________________Occupation______________________

Emergency Contact__________________________Phone (____)_____-______ Relationship _______________

Primary Care Physician _________________________________

Name of Guarantor (Person Responsible for the Account)____________________Phone (_____)_____-______

Patients' relationship to Guarantor (Circle One) Self Spouse Child Other

How did you hear about our office? (Circle one) Insurance Yelp Google Facebook Drive/walk by

I was referred by my family / friend. Name:_____________________Other: ________________________

Lifestyle Questions

Do you wear Sunglasses? Yes or No

Do you wear Contact Lenses? Yes or No If yes, which brand ______________________

Are you interested in Contact Lenses? Yes or No

Are you interested in LASIK surgery? Yes or No

Do you work on the computer? Yes or No If yes, how many hours per day? ___________

What are your hobbies? ____

Do you play any sports? Yes or No If yes, which sport? ___________________________________

	Self Yes	Self No	Family Yes
Eyes			
Glaucoma	☐	☐	☐
Macular Degeneration	☐	☐	☐
Blindness	☐	☐	☐
Dry Eyes	☐	☐	
Constitutional			
Fever or Weight Loss	☐	☐	
Ear/Nose/Throat			
Chronic Sinusitis	☐	☐	
Loss of Hearing	☐	☐	
Cardiovascular			
Diabetes	☐	☐	
High Cholesterol	☐	☐	
High Blood Pressure	☐	☐	
Respiratory			
Asthma	☐	☐	
COPD	☐	☐	
Sleep Apnea	☐	☐	
Gastrointestinal			
Ulcerative Colitis/IBS	☐	☐	
Urogenital			
Sexual Trans Infection	☐	☐	
Kidney Dysfunction	☐	☐	

	Self Yes	Self No
Musculoskeletal		
Arthritis	☐	☐
Integumentary		
Rosacea	☐	☐
Skin Cancer	☐	☐
Neurological		
Headaches	☐	☐
Migraines	☐	☐
Seizures	☐	☐
Psychiatric		
Anxiety	☐	☐
Depression	☐	☐
Dementia	☐	☐
Endocrine		
Thyroid Conditions	☐	☐
Hematologic		
Cancer	☐	☐
Lymphatic/Infectious		
Tuberculosis/positive skin test	☐	☐
Allergic/Immunologic		
Seasonal Allergies	☐	☐
Anaphylactic Shock	☐	☐
HIV/AIDS	☐	☐

If you have any of the conditions above, please explain including date of diagnosis:

____

____

Please list all your prescription and over-the-counter medications:

____

____

Please list your MEDICAL ALLERGIES:

____

Have you had any surgeries or injuries to your **eyes**? Yes or No

If yes, please explain ______________________________________

Do you smoke? Yes or No If so, how much daily________________

Financial Agreement

Insurance verification is not a guarantee of payment. We will verify and bill your insurance as a courtesy. All fees for services not covered and/or paid by insurance including co-payments and deductibles will be the responsibility of the patient's guarantor at the time services are rendered. All eyewear orders are custom-made and considered final sale at the time of purchase. We reserve the right to add a $10 finance charge monthly to any unpaid balance 60 days and older. We accept the following as payment: cash, check, Visa, Discover, Mastercard, American Express & Care Credit.

I have provided River City Eye with the names of my insurance companies for the sake of billing and I hereby authorize River City Eye to exchange information regarding my care and benefits with the provided insurance company or companies for the purpose of collecting professional fees on my behalf. I assign all benefits payable to River City Eye. To the best of my knowledge this information is accurate as of the date. I accept full responsibility for all charges related to my treatment that are not covered by my insurance.

Signature of patient or guarantor ____Date____________________

Acknowledgement of Notice of Privacy Practices

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of River City Eye's Notice of Privacy Practices. By signing below I am "only" giving acknowledgement that I have received or have had the opportunity to receive the Notice of Privacy Practices.

Patient Name (Printed) _____________________________________ Date________________________

Patient Signature____