Friedrichs Family Eye Center Optometry, PC

Patient Name: _____ DOB:_____/_____/_____

Address: _____ City_____ State_____ Zip Code_____

Home Phone_____ Occupation: _____

Work Phone_____ Employer: _____

Cell Phone_____ How did you hear of our office? ___ Insurance ___ Friend

Email_____ ___ Internet ___ Family ____Sign/billboard _____

Primary/Medical Insurance: _____ ID#_____

Cardholder Name: _____ DOB___/___/___ SSN_____ Patient is __ Spouse __ Child

Vision Insurance: _____ ID_____

Cardholder Name: _____ DOB ___/___/___ SSN_____ Patient is __ Spouse __ Child

INSURANCE: Please present your insurance ID at each visit, it is the responsibility of the patient to make accurate and detailed insurance information available to us to enable processing of his or her insurance claim. The patient is to be considered self-pay until this information is provided to us.

All co-payments and non-covered services are due at the time of service. Self-pay patients are responsible for payment in full at the time of services.

REFERRALS/AUTHORIZATIONS: It is the responsibility of the patient to obtain a referral from his or her primary care physician prior to the scheduled visit if a referral is required. If a referral is not obtained, the patient accepts full financial responsibility for all services rendered.

Insurance Authorization for Assignment of Benefits – I hereby authorize and direct payment of medical benefits to *Friedrichs Family Eye Center* on my behalf for any services furnished to me by its providers.

Vision and Medical Coverage - There are two types of insurance benefits that will pay for services and products. You may have both and our practice may accept both. *Vision care* plans only cover well visits, may have a co-pay and allow discounts on materials. They DO NOT cover diagnosis, management or treatment of eye disease, eye allergies or eye injuries. In the event that you have any eye health problems or a systemic health problem that has ocular (eye) complications, your *medical insurance* will be utilized for the services provided.

Authorization to Release Records – I hereby authorize Friedrichs Family Eye Center to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records for any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization or referral to other medical provider.

X _____ Date_____/_____/_____

Signature of Patient, Authorized representative or Responsible Party

X_____ _____

Print name of Patient, Authorized Representative or Responsible Party Relationship to Patient

Acknowledgement of Privacy Policy –

I acknowledge that I was offered a copy of the Notice of Privacy Practices for this office.

Patient Signature_____ Date_____/_____/_____

Do You or Anyone in Your Family have any of the Following Medical Conditions?

___ Heart	Self	Mother	Father	Grandmother	Grandfather
___ Lung	Self	Mother	Father	Grandmother	Grandfather
___ Diabetes _	Self	Mother	Father	Grandmother	Grandfather
___Asthma	Self	Mother	Father	Grandmother	Grandfather
___ Hypertension	Self	Mother	Father	Grandmother	Grandfather
___ HIV/AIDS	Self	Mother	Father	Grandmother	Grandfather
___ Thyroid	Self	Mother	Father	Grandmother	Grandfather
___ Cancer	Self	Mother	Father	Grandmother	Grandfather
___ Stroke	Self	Mother	Father	Grandmother	Grandfather

Do you take Plaquenil? Yes No Are you pregnant? Yes No

Do you smoke? Yes No How Much? _____

Do you drink? Yes No How Much? _____

Have You Ever Had Any of the Following: (Please check)

__Eye Surgery __Cataracts __Glaucoma ___Macular Degeneration __Diabetic Retinopathy __ Laser Vision Surgery

Please list your current medications: _____

Please list any allergies you have: _____

Primary Care Provider's Name: _____ **Pharmacy Name/Location**: _____

Do you wear eyeglasses or contact lenses? ___ Yes ___ No, how old are they? Eyeglasses _____ Contacts _____

Are you interested in new eyeglasses or contact lenses today? ___ Yes ____No ___ Eyeglasses ____Contacts

Wellness Image

A new, highly sophisticated computerized instrument now allows us to provide you with a more thorough medical analysis of the eyes. The digital retinal imaging system takes images of the back of the eye. This procedure assists the doctor in the early detection of many disorders, including glaucoma, diabetic retinopathy, macular degeneration, retinal detachments and other vision threatening conditions. The images will be stored in the computer and compared with the images from future exams. This allows the doctor to observe even the smallest amount of change from the previous exam.

The doctor strongly recommends that all patients have this procedure performed. It is especially important for people who have: Headaches, See Spots or flashes, has a family history of diabetes, glaucoma or high blood pressure, or who have high cholesterol or have reached the age of 40. All new patients should have this test for their records.

There is an additional fee of $25.00 and is due at the time of service. If a diagnosis is made as a result of this procedure, medical insurance will cover the cost of the initial photo and additional photos needed for photo documentation analysis.

___ Yes, I do want the Wellness Image today. ___ No, I do not want the Wellness Image today.

Patient Signature: _____ Date: _____/_____/_____