Patient Name:			
Birth Date:	SS#	Home Phone:	
Cell Phone:		Email Address:	
Street Address:			City:
State:	Zip Code:		

Reason for Visit:

Please note any History of the following for you, parents, Grandparents or Siblings:

Disease/ Condition	**You**	**Family**	**Relationship**
Cataract			
Glaucoma			
Macular Degeneration			
Diabetes			
Hypertension/ Heart Disease			

List any Prescription or non- prescription Medications you take: _____

Are you Allergic to any Medications?

Do you currently wear glasses and or contacts?

Who can we thank for referring you to our office?

Consent to Use or Disclose Health Information:

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct health care operations involving our office. We have a comprehensive PRIVACY PRACTICES that describe these uses and disclosure of my health information for purposes of treatment, payment and health care operations by Performance Eyecare, P.C.

SIGNATURE_____ Date_____

Insurance on File:

I certify that the information given by me in applying for insurance or Medicare payment is true and correct. I authorize my doctor to act as an agent in helping me obtain payments of these benefits directly to Performance Eyecare, P.C. on behalf for any services and materials furnished. I authorize any holder of medical information about me to release to the Health Care Financing Administration and information needed to determine these benefits payable to related services.

SIGNATURE _____ Date_____

Payment Agreement:

I understand that Performance Eyecare will bill my vision benefits and/ or health insurance. I know that I am responsible for any remaining balance after the claim is paid. Should my insurance not cover the services that are submitted in full, I agree to pay any outstanding balances.

SIGNATURE: _____ Date _____