Name:		
Birth Date:	SS#:	Home Phone:
Cell Phone:	Email Address:	
Street Address:		
City:	State:	Zip Code:
Reason for Visit:		
How did you hear about us/ who can we thank for referring you to us?		

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? Yes / No

Do you currently wear contacts? Yes / No **Are you interested in contacts? Yes / No**

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 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 P.C. will bill my medical insurance and/or vision insurance. I know that I am responsible for any remaining balance after the claim. I understand that if I have no insurance benefits, or do not want Performance Eyecare P.C. to bill my insurance, that I am responsible for payment for services received.

Signature:_____ **Date:**_____