PATIENT INFORMATION

THIS FORM MUST BE UPDATED ANNUALLY OR AS SOON AS CHANGES OCCUR.

PLEASE PRINT

TODAY'S DATE	PATIENT'S NAME FIRST MIDDLE LAST	BIRTH DATE	AGE
GENDER	HOME PHONE	WORK PHONE	CELL PHONE
E-MAIL ADDRESS	BY PROVIDING MY E-MAIL ADDRESS, I CONSENT TO RECEIVE PERIODIC NEWSLETTERS, PROMOTIONS, AND EDUCATIONAL MATERIALS FROM CAPITAL EYE. WE DO NOT SELL E-MAIL ADDRESSES. YOU CAN "OPT-OUT" AT ANY TIME IN THE FUTURE		
STREET	APT NUMBER	CITY	STATE / ZIP
	MARITAL STATUS	OCCUPATION	
YOUR OPTOMETRIST	PHONE	FAX	
YOUR MEDICAL DOCTOR	PHONE	FAX	
PHARMACY	PHONE	STREET and TOWN	

RESPONSIBLE PARTY (if other than patient)

FIRST NAME MIDDLE LAST NAME		BIRTH DATE
STREET APT NUMBER	CITY / STATE	ZIP
PHONE	RELATIONSHIP	OCCUPATION

INSURANCE INFORMATION

PRIMARY

POLICY HOLDER'S NAME, FIRST MIDDLE LAST NAME		
RELATIONSHIP		BIRTH DATE
INSURANCE CARRIER	POLICY NUMBER	GROUP NUMBER

SECONDARY

POLICY HOLDER'S NAME, FIRST MIDDLE LAST NAME		
RELATIONSHIP		BIRTH DATE
INSURANCE CARRIER	POLICY NUMBER	GROUP NUMBER

EMERGENCY CONTACT INFORMATION

IN CASE OF EMERGENCY CONTACT (REQUIRED) NAME	RELATIONSHIP
PHONE NUMBERS	

CONTINUED ON BACK

AUTHORIZATION AND INSURANCE ASSIGNMENT

I hereby authorize Capital Eye Consultants to apply for benefits on my behalf for covered services rendered. I request payment from my insurance company to be made to the above named provider. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any information to my insurance company in order to determine insurance benefits to which I may be entitled. I also authorize the release of my medical information to any physician or facility to which I am referred for diagnostic testing or other services necessary to my treatment. I may revoke this authorization at any time in writing.

CANCELLATION POLICY

Capital Eye Consultants is committed to providing all of our patients with exceptional care. When a patient cancels without giving enough notice, they prevent another patient from being seen and, therefore, we do have a cancellation policy in effect. We greatly appreciate your consideration by notifying us as far in advance as possible, however, **you are required to give this office a minimum of one business day (24 hours not to include weekends or holidays) notice** prior to the scheduled appointment. Failure to comply with this office policy will result in a **$40 cancellation fee**, which must be paid before further treatment is performed (this is also applicable to no-showing). This fee is not covered by any insurance. By signing below you are agreeing to abide by this cancellation policy and to take personal financial responsibility for the cancellation fee should you violate this agreement.

FINANCIAL AGREEMENT

I understand and agree that, regardless of my insurance status, I am responsible for my account, have read and completed all the information on this sheet and certified it to be true to the best of my knowledge, and I will notify the office of any changes. In the event my account is forwarded to collections due to lack of payment, I will be responsible for any collection and attorney fees.

PAYMENTS

I agree and understand that I am personally liable to the medical service provider for payment of any balance on my account or on any account for which I am responsible for myself or as a parent or guardian (which may include professional service fees, **missed appointment fee of $40.00**, bounced check charges, etc.) regardless of whether insurance benefits have been applied for or received, including interest on any outstanding balance(s) at the rate of 18% per annum accruing 30 days after services are rendered and for any and all collection costs or fees, including but not limited to, 50% attorney's fees and court costs if the account(s) is/are turned over to a third party and/or attorney for collection. I agree and understand that if I do not dispute in writing the amounts and charges set forth in any statement within 30 days after its issuance date that I am agreeing that the amounts and charges set forth in any statements are fair, reasonable and accurate. I agree and understand that if I file an action/counterclaim against the medical service provider/practice and the medical service provider/practice incurs any costs and attorney's fees for its/their defense, I am liable for such costs and attorney's fees if the medical service provider/practice is the prevailing party in said proceeding, which shall include, but not be limited to, bankruptcy, arbitration, mediation, litigation or other processes.

Signature _____ Date _____

Print Name _____ Relationship to Patient _____

Name_____ **Date**_____

Print name

Date of Birth _____ **Date of last eye exam** _____

List medications you currently take (prescription and over-the-counter) on the back of this page.

Do you have an **allergy** to latex? **YES** **NO**

Do you have **allergies** to any medications? **YES** **NO**

If YES, list the medication(s): _____

List all **major illnesses** (glaucoma, diabetes, high blood pressure, heart attack, etc.) or injuries (concussion, etc.):_____

_____

List any **surgeries** you have had (including eye surgeries): _____

_____

Do you have any problems in the following areas? If YES, please provide additional info on the back.

		YES	NO			YES	NO
Eyes	Poor Vision			**Muscles/Bones/Joints**	Swelling		
	Eye Pain				Joint Pain		
	Dry Eyes				Arthritis		
HIV/AIDS				**Hepatitis C**			
Constitutional	Fever			**Neurologic**	Headache		
	Unusual Weight Gain/Loss				Seizures		
	Tired				Paralysis		
Respiratory	Congestion			**Genital/Bladder**	Frequent urination		
	Wheezing				Painful urination		
	Shortness of Breath				Impotence		
Gastrointestinal	Diarrhea / Constipation			**Endocrine**	Diabetes		
	Ulcers / Hernia				Thyroid		
Cardiovascular	High blood pressure			**Blood/Lymphatic**	Bleeding Disorders		
	Heart problems				High Cholesterol		
Skin	Rash			**Psychiatric**	Anxiety		
	Growths				Depression		
Females Only:	Pregnant			**Males Only:**	Prostate		
	Nursing						

CONTINUED ON BACK

FAMILY HISTORY (Mother, Father, Grandparent, Sibling)

Has any of your immediate family members had these diseases? (father, mother, siblings, grandparents)

Blindness _____

Cataract _____

Glaucoma _____

Diabetes _____

Hypertension _____

Heart Disease _____

Stroke _____

Cancer _____

Thyroid disease _____

Arthritis _____

Other heritable disease: _____

Unknown or Adopted without knowledge of family history: _____

SOCIAL HISTORY

Does your vision limit activities of daily living (driving, reading, work, etc.)? YES ____ NO ____

Have you ever had a blood transfusion? YES ____ NO ____

Do you drink alcohol? YES ____ NO _____ If YES, how much? _____

Do you smoke? YES ____ NO _____ If YES, how much? _____ How many years? _____

VACCINATIONS

FLU	YES ____	NO _____	DATE: _____
COVID-19	YES ____	NO _____	DATE OF MOST RECENT BOOSTER: _____
PNEUMONIA	YES ____	NO _____	DATE: _____

If you have any additional information you would like to add regarding **medications you currently take, allergies to any medications, major illnesses, or any surgeries** you may have had, please specify in the box below:

Authorization for Use or Disclosure of Health Information

Our Notice of Privacy provides information about how Capital Eye Consultants may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that, by your signature, you have reviewed our notice before signing this consent.

Per HIPAA regulations (Health Insurance Portability and Accountability Act of 1996), you are afforded the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.

May we phone, email, or text you to confirm appointments?	Yes	No
May we leave a message on your answering machine at home or on your cell phone?	Yes	No
May we discuss your medical condition with any member of your family?	Yes	No

If YES, please name the members allowed to receive/discuss information about your medical condition:

_____

_____

_____
Name of Patient (Please print)

_____ _____
Signature of Patient Date

_____ _____
Signature of Patient Representative Relationship of Patient Representative to Patient

(Required if the patient is a minor or an adult who is unable to sign this form)