Welcome to Dr. Payne & Associates, P.A.

PATIENT INFORMATION

Patient's Last Name: First: MI:			Nickname:
Home Address:	City State Zip Code		
Phone: (check preferred) ❑Home: ❑Cell: ❑Work:			
Email Address:	DOB:	Gender: ❑M ❑F	Marital Status: ❑Single ❑Married ❑Other
SS#:	Employer/School:		Occupation/Grade:
Billing Address (if different):			
Parent / Guardian (if patient is a minor):	Other family members seen at this office:		
Primary Physician, Address, Phone:			Date of Last Physical Exam:
Previous Eye Doctor, Address, Phone:			Date of Last Eye Exam:
Race: ❑Asian ❑Black/African American ❑Pacific Islander ❑Native American/Alaskan ❑White ❑Declined			
Ethnicity: ❑Non Hispanic or Latino ❑Hispanic or Latino ❑Declined	Preferred Language: ❑English ❑Spanish		

INSURANCE INFORMATION

Please note: Most "Vision" plans only cover refractions and routine eye exams. Visits involving medical problems such as conjunctivitis, dry eye, ocular injuries, sudden pain or vision loss fall under your medical insurance coverage, not your "vision" plan. We do not accept insurance for medical visits. If you have any questions about your coverage, be sure to contact your insurance company, or our office, before your scheduled appointment.

Insurance Carrier:	ID#:	Policy/Group #:

If the patient is NOT the insured, please fill out the following information for the INSURED:

Name:	DOB:	SS #:	Patient's relationship to insured: ❑Spouse ❑Child ❑Other
Address (if different):		Phone:	

OCULAR / MEDICAL HISTORY

What is the main reason for your visit today?

Do you wear glasses? ☐ YES ☐ NO

If so, do you wear them for: ☐ DISTANCE ☐ NEAR ☐ BOTH

Do you wear contact lenses? ☐ YES ☐ NO

Date of last eye exam? _____

Date of last medical exam? _____

Do you have allergies to medication? ☐ YES ☐ NO

_____

Do you have seasonal allergies? ☐ YES ☐ NO

Are you pregnant? ☐ YES ☐ NO

Do you see flashes of light? ☐ YES ☐ NO

Do you see floating objects? ☐ YES ☐ NO

Do you have blackouts of vision? ☐ YES ☐ NO

Do you have frequent headaches? ☐ YES ☐ NO

Do you smoke? ☐ YES ☐ NO

Do you drink alcohol? ☐ YES ☐ NO

Current Medications:

_____

_____

Current EYE Medications:

_____

_____

Do you have:

- ☐ No health conditions
- ☐ Cancer
- ☐ Diabetes Type ___
- HbA1c ___% LBS ___mg/dl
- ☐ High Cholesterol
- ☐ Hypertension
- ☐ Lung Disease
- ☐ Multiple Sclerosis
- ☐ Rheumatoid Arthritis
- ☐ Sarcoidosis
- ☐ Thyroid Disease
- ☐ Other _____

Have You Ever Had:

- ☐ NONE
- ☐ Amblyopia (Lazy Eye)
- ☐ Cataracts
- ☐ Diabetic Retinopathy
- ☐ Dry Eyes
- ☐ Glaucoma
- ☐ Iritis
- ☐ Macular Degeneration
- ☐ Optic Nerve Disease
- ☐ Retinal Detachment
- ☐ Retinal Disease
- ☐ Strabismus (eye turn)

Have you had Eye Surgery For:

- ☐ No Eye Surgery
- ☐ Cataracts
- ☐ Foreign Body Removal
- ☐ LASIK / PRK / RK
- ☐ Eye Muscle Surgery
- ☐ Retinal Detachment
- ☐ Trauma
- ☐ Other _____

Has Any Family Member Had:

	M	F	GM	GF	SIBLING
☐ NONE					
Blindness	☐	☐	☐	☐	☐
Cataracts	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐
Macular Degen.	☐	☐	☐	☐	☐

☐ Other _____

☐ Adopted / Unknown History

Occupation: _____

Hrs per day spent on computer _____

Common Medications:

Place a check next to any medication that you currently take. The common brand and generic names are listed.

	Abilify (Aripiprazole)		**Flomax (Tamsulosin)**		**Nasonex (Mometasone Furoate)**
	Actos (Pioglitazone)		**Flonase**		**Nexium (Esomeprazole)**
	Advair		**Folic Acid (vitamin for anemia)**		**Norvasc (Amlodipine Besylate)**
	Advil (Ibuprofen)		**Gabapentin (Neurontin)**		**Novolog (fast acting Insulin)**
	Albuterol (Proventil)		**Glucophage (Metformin)**		**Paxil (Paroxetine)**
	Ambien (Zolpidem)		**Glimepiride (Amaryl)**		**Plaquenil (Hydroxychloroquine)**
	Amoxicillin		**Glipizide (Glucotrol)**		**Plavix (Clopidogrel)**
	Aspirin		**Glyburide (Miconase, DiaBeta, Glynase)**		**Pravachol (Pravastatin Sodium)**
	Atenolol (Tenormin)		**Hydrochlorothiazide (Microzide)**		**Prednisone (Detasone)**
	Azithromycin (Z-Pak or Zithromax)		**Hydrocodone-Acetaminophen**		**Prilosec (Omeprazole)**
	Benicar (Olmesartan)		**Insulin / Lantus**		**Prozac (Fluoxetine)**
	Bystolic (Nebivolol)		**Lexapro (Escitalopram)**		**Restasis (Cyclosporine)**
	Calcium Acetate		**Lipitor (Atorvastatin)**		**Singulair (Montelukast)**
	Coreg (Carvedilol)		**Lisinopril (Prinivil, Zestril)**		**Synthroid (Levothyroxine)**
	Crestor (Rosuvastatin)		**Lumigan (Bimatoprost)**		**Toprol (Metoprolol Succinate)**
	Cozaar (Losartan Potassium)		**Metformin Hydrochloride (generic for Glucophage)**		**Travatan (Travoprost)**
	Cymbalta (Duloxetine)		**Mevacor (Lovastatin)**		**Tricor (Fenobibrate)**
	Diovan (Valsartan)		**Mobic (Meloxicam)**		**Xalatan (Latanoprost)**
	Enalapril Maleate (Vasotec)		**Micardis (Telmisartan)**		**Zocor (Simvastatin)**
	Epogen (Epoetin alfa)		**Naproxen (Midol, Aleve)**		**Zoloft (Sertraline Hydrochloride)**

Other medications *NOT* listed above: _____

Financial Responsibilities and Consent

Patient Name: _____ DOB: _____

Financial Responsibilities:

- You (or your legal guardian) are responsible for the payment of your account including co-pays, coinsurance, deductibles, all other procedures or treatments not covered by his / her insurance plan and all direct or indirect fees incurred in collecting any outstanding balance.
- While we will assist in filing for insurance, we cannot guarantee coverage. You are responsible for knowing your insurance benefits and requirements for coverage and ensuring that any necessary referrals or authorizations are obtained before receiving services. In the event a claim is rejected, you will be responsible for payment.
- We may file some types of insurance for you; however, you are responsible for staying in contact with your insurance company to assure that they pay in a timely matter. Payment is due at the time of service. We accept cash, checks, Visa, MasterCard, Discover and American Express.
- Please bring your insurance card and picture ID with you to each visit, and notify us of any changes such as address or phone number.
- There will be a $25.00 fee plus our bank's fee for a returned check.

Cancelled Appointments:

We ask that you give us at least a 24 hour notice on all cancelled appointments. If you repeatedly miss appointments without any notification, you will only be seen on a walk-in basis. Insurance does not cover missed appointments.

Records Release:

We will provide a report of your most recent exam results and current spectacle and contact lens prescription at no charge. All charges and balances must be paid in full prior to release as well as signing a record release form.

Acknowledgements:

- I have read, understand and agree to the policies outlined above.
- I consent to the performing of optometric procedures agreed to be necessary or advisable.
- I authorize the release of any information contained in my records for the purpose of my treatment, billing and processing of insurance claims, and I authorize payment of benefits to Dr. Payne & Associates, P.A.
- The duration of this document is indefinite and continues until revoked in writing.

Signature _____ Date_____

Print Name (and relation, if parent / Guardian)_____

Notice of Privacy Practices:

I acknowledge that a copy of the Dr. Payne & Associates, P.A Notice of Privacy Practices has been made available to me in both English and Spanish.

Signature_____ Date_____