PATIENT INFORMATION

Please answer all questions: Email _____ Todays Date_____

Patient's Mr. /Mrs./ Ms./ Dr. Single/Married/Other/Child

Last Name_____First Name_____Age_____Birth Date_____

Address _____Apt. No ___City_____State_____Zip_____

Home Phone _____Work _____Cell _____

Social Security No. _____Referred by: _____

Employer_____Occupation _____

Business Address_____City_____State_____Zip_____

To whom should statement be sent other than yourself? _____

Address _____

Name of spouse_____Birth Date_____SS#_____

Name of Minor Children with ages_____

_____Name of School_____Major_____

Emergency Contact/Telephone Number_____Name_____

Date of last eye exam_____Dilated? Y/N Language Preference? _____

Insurance Information;

Vision Plan:_____**Policy#**_____

Name of policy holder_____**Birth Date**_____***SS*#**_____

Primary Insurance_____Social Security #_____

Name of Insured: Parent, Spouse or Covered Member Name_____Birth Date_____

Relationship to Patient_____Policy # _____Group_____

Secondary Insurance_____Social Security #_____

Name of Insured: Parent, Spouse or Covered Member Name_____Birth Date_____

Relationship to Patient_____Policy # _____Group_____

Personal Medical Information;

What is your general health?_____

Do you feel a change is needed in your prescription: Yes or No To see clearly at distances that are Far___Near___

Date Last Eye Exam _____ Last Eye Exam any abnormalities? Yes or No Dilated? Yes or No

Do you have any problems with any of these systems?

General Health: Complete the following if past or present. (Circle Yes or No)

Y/N	Respiratory	Y/N	Eyelid Diseases	Y/N	Allergic/immunologic	Y/N	Iritis
Y/N	Cardiovascular	Y/N	Musculoskeletal	Y/N	Blood/Lymph	Y/N	Dry Eyes
Y/N	Ears/Nose/Throat	Y/N	Genitourinary	Y/N	Endocrine	Y/N	Color Blindness
Y/N	Gastrointestinal	Y/N	Floaters or Flashes	Y/N	Mental	Y/N	Heart Disease
Y/N	Allergies	Y/N	Surgical Operations	Y/N	Macular Degeneration	Y/N	Multiple Sclerosis
Y/N	Asthma	Y/N	Eye Diseases	Y/N	Eye exercises	Y/N	Arthritis
Y/N	Cataracts	Y/N	Eye Surgery	Y/N	Corneal Ulcer	Y/N	Crohn's Disease
Y/N	Fainting	Y/N	Eye or Head Injuries	Y/N	Thyroid Disease	Y/N	Systemic Lupus
Y/N	Hay fever	Y/N	Glaucoma	Y/N	Skin Conditions	Y/N	Anxiety
Y/N	Drug Sensitivity	Y/N	Headaches:	Y/N	Crossed or Lazy Eye	Y/N	Nervous
Y/N	High Blood Pressure		Caused by _____ Location_____				Other_____
Y/N	Retinal disease or detachment						

If Yes please describe briefly:

_____

Diabetes: Y/N Type_____ Date of Diagnosis_____ Controlled _____
Allergies Y/N Allergic to what?_____What happens?_____
Medication allergy? Y/N Allergic to what?_____What happens?_____
Are you presently taking any medications or hormones including Birth Control Pills? Yes or No
If Yes, what medications are you taking? _____
Date of last health exam_____ Do you have any other health problems listed or not? _____
_____ Date of last tetanus shot?_____
Name of family doctor_____Date of last visit?_____
Have you had any operations? Y/N What kind?_____When?_____
Do you use cigarettes/tobacco?_____Alcohol?_____Other Substance(s)?_____

Family Medical History;

Has anyone in your family had? (Circle Yes or No)

Y/N	Diabetes/ Relation____	Y/N	Eye Diseases / Relation____	Y/N	Glaucoma / Relation____
Y/N	Glaucoma/ Relation	Y/N	Macular degeneration/Relation____		
Y/N	Heart Disease / Relation____	Y/N	Tuberculosis / Relation____	Y/N	Keratoconus / Relation___
Y/N	Retinal Detachment/ Relation	Y/N	Cataracts/ Relation____		
Y/N	Blindness / Relation____	Y/N	To wear Eyeglasses / Relation____	Y/N	Color Blind / Relation____
Y/N	High blood pressure / Relation____		Other eye conditions?_____		

Personal Eyecare Information;

Age of present eyeglasses or Contact Lenses _____
Have you had Vision Correction Surgery? Yes or No Are you interested in Vision Correction Surgery? Yes or No
If Yes, which Refractive Surgery?_____ Any one Surgeon or Institute in particular? _____
Do you experience any eyestrain? (i.e. pain of any sort, spots, or twitching of the eyelids) Yes or No
If yes, When: _____ How often:_____
Have you ever worn Contact Lenses? Yes or No If Yes, when were you last fit? _____
Do you wear Contact Lenses now? Yes or No If No, why did you quit?_____
Are you interested in wearing contacts now and which ones? _____
Have you ever had visual training? Y/N If yes, what age(s)?____ Has anyone in your family had visual training? Y/N
Hobbies and Interest_____

Doctor's Comments:_____
_____
_____

Doctor's Signature_____Date:_____
Doctor's Signature_____Date:_____
Doctor's Signature_____Date:_____

Medical History Updates
Date: Comments:

_____
_____
_____
_____

*****PLEASE READ AND SIGN BELOW*****

Authorizations to release Medical Record Information and Assignment to Pay Provider Directly:
Please Check Purpose of Visit:

___Annual visual analysis, refraction & glaucoma check ___Contact lens evaluation ___School referral
___Emergency office visit/Consultation ___Laser vision consultation ___Accommotrac Screening
___Sport vision evaluation ___Glasses, sunglasses, sport or safety glasses ___Frame, lens repair, replace, adjustment

◆ I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I authorize this vision care provider to apply for benefits on my behalf for any services or materials furnished. I authorize payment of these benefits directly to Dr. Michael Spitzer, to which I am entitled. I assign my benefits from my insurer be made directly to the vision care provider and authorize any holder of medical information about me to release to the Medical Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services. I understand that I am financially responsibility for charges not covered by my insurance. A photocopy of this authorization will be considered as valid as the original copy.

Patient Signature:_____

(Parent/Guardian, if minor)

◆ I herby acknowledge that I have received a copy of this medical practice Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, ant that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

A copy of any amended Notice of Privacy Practices may be delivered by email or USP service. This medical facility may leave a message on my phone message service at contacts given and/or phone numbers, concerning my medical treatment as needed, unless otherwise indicated._____

Vision Insurance Plan Y/N If yes VSP, Eyemed, Davis, Other_____

If patient is a minor, name of responsible parent, who will pay this account_____

Patient Name_____Date of Birth_____

I_____, consent that Dr. Michael Spitzer can release my medical records to the above specified individual for their insurance company.

PLEASE READ CAREFULLY: I understand that my medical records are confidential. I understand that by signing this consent form I am allowing my medical information to be released upon the insurance company's request, for the purpose of Health Care Operations (including, but not limited to, provider review functions, claims payment and quality assessment). I also understand that I may revoke this consent by written request, at any time, with this doctor. If revoked, it is understood by all parties that all information released prior to being notified of such revocation was made with my consent.

I understand that I have the right to restrict the disclosure of specific information on my medical records if I request such restriction in writing. I also understand that my request for restriction may be denied if the information restricted is required for Health Care Operations.

I have read the above and forgoing consent for release of information. I do herby acknowledge that I am familiar with and fully understand the terms and conditions of consent.

I understand that if my insurance company does not pay the full amount due, I will be responsible for the remaining balance. A photocopy of this authorization will be considered as valid as the original copy.

Please check your preferred method of payment Check Cash Visa MasterCard Discover AMEX

If not signed by the patient, please indicate relationship:

◆parent or guardian of minor patient ◆guardian or conservator of an incompetent patient

◆beneficiary or personal representative of deceased patient

Date_____I hereby guarantee payment of service;

Patient Signature:_____

(Parent/Guardian, if minor)