Gowanda Eye Care

Patient Name:_____Date____/____/___

D.O.B.___/____/___Email:_____Home Phone: (___)_____-_____

Address:_____Cell Phone: (____)_____-_____

City:_____State:_____Zip Code:_____

Primary Care Doctor:_____Address:_____

Phone: (_____)_____-_____

Parent or Guardian's Name (if under 18):_____

Referred by:_____Reason for visit:_____

Date of last eye exam: __ ___/_____/_____

Occupation:_____

Do you see any other eye doctors? Y / N

If so, who and for what condition?_____

List any work activities or hobbies you participate in that may require special visual needs:

_____

Please give insurance card(s) to receptionist or fill in the information below:

Vision Insurance (if any): _____ ID Number: _____ Insurance members name (if different): _____ DOB ___/___/___	Health Insurance (if any): _____ ID Number: _____ Insurance members name (if different): _____ DOB ___/___/___

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Please give insurance card(s) to receptionist or fill in the information below:

Vision Insurance (if any):

_____

ID Number:

_____

Insurance members name (if different):

_____ DOB ___/___/___

Health Insurance (if any):

_____

ID Number:

_____

Insurance members name (if different):

_____ DOB ___/___/___

Please fill out the following survey to the best of your ability. All questions are important for the complete and comprehensive care of your eyes. Thank You.

1. **Please mark any of the following problems you are having:**

- o Blurred vision
- o Double vision
- o Dry eyes
- o Itching
- o Flashes
- o Floaters
- o Eye pain
- o Light sensitivity
- o Water eyes/tearing
- o Double vision
- o Contact lens discomfort
- o Other:

2. **Please circle any of the medical conditions that you or a family member have:**

Diabetes	Self or Relative	Arthritis	Self or Relative
High Blood Pressure	Self or Relative	Multiple Sclerosis	Self or Relative
High Cholesterol	Self or Relative	Thyroid Condition	Self or Relative
Asthma	Self or Relative	Sleep Apnea	Self or Relative
COPD	Self or Relative	Inflammatory Bowel Disease	Self or Relative
Lupus	Self or Relative	Other:	

3. **Please circle any eye conditions you or a family member have:**

Cataracts	Self or Relative	Blindness	Self or Relative

Glaucoma	Self or Relative	Lazy eye/ Eye turn	Self or Relative
Macular Degeneration	Self or Relative	Other:_____	

4. **Are you currently pregnant or nursing? Y/N**

5. **Please list all allergies (medication and seasonal)**

6. **Please list all medications (prescription and over the counter) and eye drops used:**

CONSENT TO THE RELEASE OF MEDICAL INFORMATION

I authorize the release and disclosure of any and all of my medical records to any other entity including, but not limited to, referring physicians, hospitals or other health care providers which may be of assistance in the opinion of this office in providing for the treatment of the patient.
I authorize this office and its employees to release and disclose all or any part of the patient's medical records to any entity which is, or may be, liable for all or any part of the provider coverage.
I authorize the release of medical records necessary to assist in the reimbursement of benefits to which I may be entitled.
I authorize this office and its employees to release via fax and/or electronic/internet transmission medical records, which are needed in order to provide the patient with the appropriate medical care.

CONSENT TO FINANCIAL RESPONSIBILITY

All fees are due and payable at the time when services are rendered unless arrangements have been made ahead of time with appropriate staff.
We will accept direct assignment of your claim if it is allowable. However, please know that you will still be responsible for any non-covered services, such as deductibles, co-pays or co-insurance, etc.
If your claim is denied, please know that you will be responsible for services rendered.
You are responsible for charges incurred from an overdrawn account. It is our policy to charge a fee of $25.00, in addition to the billing charges for incurred bank surcharges.

INSURANCE COVERAGE WAIVER

I understand that if my eligibility for coverage by my insurance cannot be confirmed at this time, I still wish to receive medical services from South Park Optical. If it is determined that I am not eligible for coverage, I understand that I will be responsible for payment for all services provided.

REFERRAL WAIVER

I understand that if my insurance company requires a referral and I do not obtain a referral, I will be responsible for payment for all services provided. It is the patient's responsibility to know if a referral is required.

CONSENT FOR THE ASSIGNMENT OF BENEFITS
I authorize direct payment of medical benefits to this office from the listed insurance carrier. The signature furnished below shall suffice for all insurance forms on a continuing basis.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
I acknowledge that I have received a copy of this office's Notice of Privacy Practices and/or it is posted and readily available for me to read.

I consent to all of the above:

Patient Name (please print):_____

Patient Signature:_____Date____/____/____
(Over age 18)

Parent or Guardian Name (please print):_____

Parent or Guardian Signature:_____Date____/____/____
(If patient under 18)