EYE & VISION CARE OF SANTA BARBARA

Confidential Patient Information

Welcome, and thank you for choosing our office for your eye care needs. Please take time to complete this form. If you have any questions or concerns, do not hesitate to ask for assistance.

PATIENT INFORMATION

Name: (Mr., Mrs., Miss, Ms., Dr.) _____ Sex ☐ M ☐ F
LAST FIRST MI

Date of Birth: _____ Social Security #: ___ ___ ___-___ ___-___ ___ ___ ___ Referred by: _____

Home Address: _____City _____State ____ Zip _____

Home Phone: _____Work Phone: _____ Cell: _____

E-mail Address: __

Employer: _____ Occupation: _____ Vision Insurance: _____

Primary Insured's Name: _____ Insured's Date of Birth: _____ Insurance ID #: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____ Phone Number: _____

Please list family members who are currently patients of ours: _____

PERSONAL/FAMILY HISTORY/REVIEW OF SYSTEMS: *Please check all that apply to you or your **immediate** family.*

	You	Family		You	Family		You	Family
Blindness	☐	☐	Retinal Disease	☐	☐	Heart Disease	☐	☐
Eye Turn/Lazy Eye	☐	☐	Other Eye Disease	☐	☐	Respiratory/Ear, Nose &Throat	☐	☐
Glaucoma	☐	☐	Eye Surgery	☐	☐	Bones/Joints/Muscle (e.g. Arthritis)	☐	☐
Cataract	☐	☐	Cancer	☐	☐	Skin (e.g. Rashes, Rosacea)	☐	☐
Macular Degeneration	☐	☐	Diabetes	☐	☐	Endocrine Disorders (e.g. Thyroid)	☐	☐
Retinal Detachment	☐	☐	High Blood Pressure	☐	☐	Other _____	☐	☐

Type of *any **surgeries*** and date: _____

Please list *any and all **medications*** (over-the-counter or prescription, including birth control and vitamins) you are taking: _____

_____

Do you have any allergies? _____

Who is your family physician? _____ Date of last Physical Exam: _____

Female patients: Are you pregnant or nursing? ☐ Yes ☐ No Delivery Date: _____

CONSENT AND AUTHORIZATION

I acknowledge and understand that I am responsible for all of the charges for services and materials rendered to me or to the person named above for which I am responsible. I further understand that the billing to my insurance company or Medicare in no way relieves me of responsibility for payments, co-payments or payments for non-covered services and materials due to Eye & Vision Care. I understand that delinquent balances are subject to finance charges and that the account may be sent to a collections agency. I hereby authorize my insurance company to pay proceeds for any benefits otherwise due to me directly to Eye & Vision Care. ___*initial*

I authorize the release of any medical information, by electronic or other means, to process insurance claims, or for use in medical research. I understand by signing this form I am allowing my medical information to be released to my insurance company, primary care physician and specialists for the purpose of health care operations or medical research, as described in our *Notice of Privacy Practices.* I understand that I may revoke this consent by written request at any time. ____*initial*

ASSIGNMENT OF MEDICARE BENEFITS

(if applicable)

Eye and Vision Care Optometric Group is a Medicare participating provider. Therefore, we will bill Medicare directly. Medicare will send payment directly to our office. This payment will consist of 80% of the Medicare Part B approved charges. I understand that I will be responsible for the yearly deductible and 20% of approved charges. I have been informed that not all services are covered by Medicare (e.g. eye refractions). My signature below further verifies that I have not joined an HMO or other entity in which my Medicare benefits have been relinquished. _____ *N/a* ____*initial*

_____ _____

Patient's Signature or Authorized Representative Date