Today's Date:_____

Last:_____First_____MI___

Street_____

City_____State_____Zip_____

Home Phone_____Work_____

Patient's DOB_____Patient's SSN_____

Employer_____

Occupation (or school)_____

Spouse (or parent's name)_____

Email Address_____

What is the major purpose of this visit?_____

_____

Any problems with your current contact lenses or glasses?____

_____

Who may we thank for referring you to our office?

_____

If not referred, how did you choose our office for your needs?

☐ Insurance List ☐ Saw Sign/Building ☐ Newspaper
☐ Yellow Pages: Which directory?_____
☐ Webpage: Which website?_____
☐ Other:_____

Insurance Information

Vision Insurance:_____

Subscriber Name:_____

Subscriber SSN:_____Birth Date:_____

Medical Insurance:_____

Subscriber Name:_____

Subscriber SSN:_____Birth Date_____

The information in this confidential case history form is critical to the evaluation of your vision and health.

Have you been diagnosed or treated for the following:

☐ Cataract ☐ Iritis/Uveitis
☐ Corneal Abrasion ☐ Lazy Eye
☐ Eye Infection ☐ Macular Degeneration
☐ Eye Injury ☐ Retinal Detachment
☐ Glaucoma ☐ Other:_____

Is there a family medical history of the following?

	Relationship
Blindness	☐_____
Cataracts	☐_____
Corneal Problems	☐_____
Glaucoma	☐_____
Lazy Eye	☐_____
Macular Degeneration	☐_____
Retinal Problems	☐_____
Diabetes	☐_____
Heart Disease	☐_____

Patient Medical History

Name of Family Physician_____
Town_____
Date of Last Physical Check Up_____
Current Medications (Rx or Over the Counter)

_____
_____
_____

Allergies to Medications ☐Yes ☐No

_____

Have you ever been diagnosed or treated for the following:

☐ Allergies ☐ Diabetes ☐ Thyroid
☐ Asthma ☐ Heart Disease ☐ Other_____
☐ Arthritis ☐ High Blood Pressure _____
☐ Cancer ☐ Kidney _____
☐ Cholesterol ☐ Nerves

Patient Eye History

Date of Last Eye Exam:_____
By whom?_____
Do you currently wear contact lenses ☐ Yes ☐ No
What kind?_____
Solutions used:_____
Have you tried Contact Lenses? ☐ Yes ☐ No

Do you experience or have you experienced?

☐ Blurry Vision ☐ Flash of light ☐ Burning
☐ Floaters/spots ☐ Crossed eye ☐ Grittiness
☐ Tearing ☐ Itchiness ☐ Double Vision
☐ Headaches ☐ Trouble seeing at night
☐ Sunlight sensitivity ☐ Uncomfortable glasses

Do you.....(Check box if your answer is yes)

☐ Work at a computer?
☐ Spend time outdoors?_____ Hours per week
☐ Have prescription sunglasses?
☐ Think you might benefit from thinner, lighter lenses?

If you wear bifocals do the lines or head tilting bother you?
☐ Yes ☐ No
If you wear contacts are you satisfied with the vision and comfort?
☐ Yes ☐ No

Precision Eyecare

Cancellations

In consideration of others, please let us know as soon as possible if you are unable to keep a scheduled appointment. Cancellation of appointments must be made at least 24 hours in advance to avoid a charge.

Insurance Coverage

As a courtesy, we will bill your insurance company for you. However, it is your responsibility to make sure that your account is paid in full regardless of insurance payment.

Our primary concern is to safeguard your vision and eye health and not to provide services limited only to those covered under your particular insurance plan. Some companies arbitrarily select certain services and materials they will cover. Your insurance is a contract between you, your employer and your insurance company - we are nota party to that contract. Please ensure that you are familiar with your particular plan.

Payment Policy

Payment in full is expected at the time of your appointment. We accept Visa, MasterCard, American Express, Discover, personal checks and cash. If any payments not covered by insurance are not recieved within sixty (60) days from the date of service, a 1.9% monthly finance charge (22.8% APR) will apply.

Returned Checks

There is a $25.00 service charge for all checks returned by the bank.

Receipt of Notice of Privacy Policies & Consent Form

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services and to conduct health care operations involving our office.

I acknowledge that I have had the opportunity to review the *Notice of Privacy Practices* and the *Patient Bill of Rights* (a full copy is available in the Precision Eyecare waiting area).

Assignment of Benefits

I authorize my insurance company to make payment directly to Dr. Daniel J. Morrill, of any benefits otherwise payable to me. I understand that I am responsible for any charges not paid by my insurance company within sixty (60) days. Regardless of any insurance coverage, the total balance is the legal responsibility of the patient. A copy of this authorization shall be valid as the original.

Release of information: I _____ hereby authorize Dr. Daniel J. Morrill to furnish information concerning my care to my insurance company.

I have read and understand the above policies: _____

Please sign