10860 Park Road Suite 105, Pineville, NC 28134

OFFICE: (980) 237 – 9704 FAX: (980) 237-9987 EMAIL: Accuvisiondryeye@gmail.com

Date: ___________________

Patient Name: ____ Date of Birth: ________________________

Address: ____ City: ____________ State: _____ Zip:________

Sex: Male / Female Marital Status: Married / Single / Widowed

Home Phone:____________________Cell Phone:_____________________Email:__________________________

Emergency Contact Name/ Phone:______________________________Social Security # _________________

Employer:____________________________________ Occupation: ___________________________________

----------*Insurance*----------

Insurance Provider:_____________________________Policy Holder: ____________________________________

Holders Date of Birth:__________________________Policy Number: ____________________________________

----------*Primary Care*----------

Primary Care Doctor Name/ Phone: ____

Primary Eye Doctor:_________________________________Rheumatologist:______________________________

Pharmacy Name/ Location: ____

----------*Medical History*-----------

Check if you or anyone in your immediate family has any of the following:

	Self	Family		Self	Family
Hypertension	____	____	Dry Eye	____	____
Diabetes	____	____	Eye Trauma	____	____
Cholesterol	____	____	Floaters	____	____
Asthma/COPD	____	____	Glaucoma	____	____
Gastrointestinal	____	____	Lazy Eye/Eye Turn	____	____
Neurological	____	____	Blindness	____	____
Thyroid	____	____	Retinal Detachment	____	____
Muscle/Joint	____	____	Cataracts	____	____
Stroke	____	____	Macular Degeneration	____	____
Ear/Nose/Mouth	____	____	Itchy Eyes	____	____
Anxiety/Depression	____	____	Seasonal Allergies	____	____
Heart Attack	____	____	Headaches/Migraines	____	____
HIV/AIDs	____	____			
Cancer	____	____			

Past Surgeries/ Procedures: ____

____

Continue on back →

Please list all of your Medications / Eye Drops (*name, dosage and frequency*):

____ ____
____ ____
____ ____
____ ____
____ ____

Medication Allergies:

____ ____
____ ____

Do you? Recreational Meds:_____Smoke:_____Drink: _____

Do you Wear Contacts: Y / N   Replacement Frequency?_________Do you sleep in contacts? Y / N

HIPAA POLICY/DISCLAIMER:

I have read and understand the HIPAA policy (effective April 14, 2003) presented before me. I understand that all information and correspondence regarding my health care will remain confidential. I am fully responsible for any and all follow up care that may be recommended by the health care professional.

INSURANCE DISCLAIMER:

Thank you for choosing Accuvision Dry Eye. We really appreciate your business!

Because we accept a wide variety of insurance plans with many kinds of restrictions imposed by the insurance companies, we want to make sure you understand your responsibilities as an insurance-based customer. We will make our best effort to work with your insurance plan.

You are responsible for:

- Confirming that you are currently eligible for the insurance benefits.
- Providing us with the most current information about your coverage
- Informing us of any co-payments that you are required to pay.

The provisions of your insurance policy may change from one date of service to the next. Please make sure that you are aware of changes so that you can maximize your current benefits. Your insurance company can assist with this.

Sometimes, following an examination, an insurance carrier may not reimburse us for the expected amount (e.g., because you are no longer covered or because you purchased a non-covered item/service). If this happens, you will be responsible for the unpaid balance; this will be billed directly to you.

We apologize that the complexity of medical insurance makes it necessary for you to confirm your understanding of this policy. Your signature below indicates that you understand and comply with our Customer Responsibility Policy. Thank you for giving us the opportunity to satisfy your medical needs.

Patient Signature:______________________________   Date:______________