Premier Eye Care
AND CONTACT LENS SERVICES

New Patient Form

~ MUST FILL IN BLANKS WITH A * SYMBOL~

*Last: ______________________ *Address: ______________________.

*First: ______________________ *Zip: __________ *State ______________.

*DOB: ______________________ *City ______________________.

Gender: ______________________ SSN: ______________________.

*Phone#: ______________________ Email: ______________________.

Medical History

Last check up______________ Primary doctor______________.

List any serious medications______________________.

*Allergic to any medications? (YES/NO) If so, list here______________.

Diabetic? (YES/NO)

Bothered by bright lights? (YES/NO)

Do you work outside? (YES/NO)

Do you play sports? (YES/NO)

Bothered by glare at day or night? (YES/NO)

Do you use power tools? (YES/NO)

Do you work on computers or tablets? (YES/NO)

Have you worn contacts? (YES/NO)

I authorize Premier Eye Care to release any medical information to my insurance company (if not self pay) and its agents that may be needed to determine benefits for service. I understand that this information will be used by the eye doctor to help determine appropriate and healthful eye treatment. If there is any change in my medical status, I will inform the eye doctor.

I authorize my insurance company to pay ideal benefits otherwise payable to me for services rendered. I authorize Premier Eye Care to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

I agree to...ALL SALES ARE FINAL!
WE REQUIRE AT LEAST HALF DOWN DAY OF APPOINTMENT.
MATERIALS MUST BE PAID IN FULL TO RECEIVE.
Once materials leave the store they CAN NOT be returned
6 months to pick up materials or materials will be dispensed
1 year MANUFACTURER warranty on Frame and Lens Materials

*Signature:______________________________ Date:______________

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Patient HIPAA Release Form

The Health Insurance Portability & Accountability Act of 1966(HIPAA) is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper or orally be kept confidential. A copy of this policy is available to you at your request in our office.

The Doctor and Staff at Premier Eyecare and Contact Lens Services may release information on my health to the following individuals.

NAME: ____________________
RELATIONSHIP: ____________________

NAME: ____________________
RELATIONSHIP: ____________________

NAME: ____________________
RELATIONSHIP: ____________________

PATIENT:

NAME ______________________________

SIGNATURE ______________________________

DATE ____________________