Premier Eye Care
AND CONTACT LENS SERVICES
Look Your Best. See Your Best

WELCOME TO OUR OFFICE

Date_____

Patient Information

Last_____ First_____ Middle Initial_____

Address_____ City_____ State_____ Zip Code_____

Home Phone_____ Work or Cell_____ Date of Birth / /

Employer_____ Email Address_____

Responsible party/Parent's Name_____ VSP insurance last 4 or SS#_____

Patient Medical/Social History

Name of Family Physician_____ Date of Last Check-up_____

Current Medications (Prescription and Over the Counter Meds)

_____

Are you allergic to any medications? ☐ Yes ☐ No If yes, which_____

List any Hobbies (sports, quilting, woodworking, etc) _____

Height_____ Weight_____ Blood Pressure_____/_____

Eye History

Have you ever experienced, been treated for or diagnosed with any of the following:

- ☐ Blurry Vision
- ☐ Double Vision
- ☐ Flashes of light
- ☐ Floaters
- ☐ Crossed/Lazy Eyes
- ☐ Other_____
- ☐ Tearing
- ☐ Dryness
- ☐ Burning
- ☐ Eye injury or infection
- ☐ Sunlight Sensitivity
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Macular Degeneration
- ☐ Retinal Detachment
- ☐ Headaches

How did you hear about us?

- ☐ Insurance List
- ☐ Radio
- ☐ Saw Sign or Building
- ☐ Phone Book
- ☐ Newspaper
- ☐ Internet

Join us on Facebook and learn about any future Frame Sales or general information on your eye health.

SIGNATURE ON FILE

I request that payment of authorized insurance benefits for any services furnished to me be made on my behalf to Dr. Michael Gilbreath. I authorize Premier Eyecare and Contact Lens Services to release any medical information to my insurance company and its agents that may be needed to determine these benefits or benefits for related services.

Signature _____

Date_____

Premier Eye Care
920 E 56th St Suite D3
Kearney, NE 68847

Acknowledgement of Notice of Privacy Practices

Patient Name_____
(Last) (First) (Middle Initial)

_____

I have received Premier Eye Care's Notice of Privacy Practices

_____ _____
Signature of Patient/Parent/Legal Guardian Date

_____
Relationship to Patient

_____ _____
Witness Date

Documentation of Good Faith Effort

- Attempted to distribute the Notice of Privacy Practices to the Patient/Parent/Legal Guardian, but the patient/legal guardian declined to acknowledge the receipt of the Notice of Privacy Practices.
- Patient/Parent/Legal Guardian directed to ECA website to view the Notice of Privacy Practices.
- The Notice of Privacy Practices was mailed to the Patient/Parent/Legal Guardian.
- Other_____

_____ _____
Witness Date