WELCOME TO OUR OFFICE

Thank you for choosing our office

In order to serve you properly, please provide the following information. **Print clearly and leave no blanks**.

Patient Name _____ Today's Date _____
First (given name) Middle Initial Last Nickname

Address _____ City _____ State _____ Zip _____

Birth Date _____ Social Security Number _____

Home/Land Phone _____ Daytime/Cell Phone _____

E-Mail Address _____
(For use with our electronic scheduling system. Strictly confidential. Not to be used for marketing purposes.)

Marital Status: ☐ single ☐ married ☐ widow ☐ divorced ☐ separated

If patient is a minor, who may authorize treatment? _____ Relationship _____

Occupation _____ Employer _____ Work Phone _____

Please select the racial category with which you most closely identify. Check as many as apply:

☐ White ☐ Asian ☐ Black/African American ☐ American Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander

Are you Hispanic or Latino? ☐ Yes ☐ No

Whom should we thank for referring you? _____

VISION INSURANCE (Insurance companies require the below information for billing purposes.)

Name of Primary _____ Relationship to Patient ☐ self ☐ spouse ☐ parent ☐ guardian

Primary's Social Security # _____ Primary's DOB _____

Insurance Co. Name _____ Policy # _____ Group ID # _____

MEDICAL HEALTH INSURANCE

Insurance Co. Name _____ Policy # _____ Group ID # _____

ADDITIONAL INSURANCE

Name of Insured _____ Relationship to Patient ☐ self ☐ spouse ☐ parent ☐ guardian

Insured's Social Security # _____ Insured's DOB _____

Insurance Co. Name _____ Policy # _____ Group ID # _____

Emergency Contact Info:

Name _____ Phone _____

Relationship to Patient ☐ spouse ☐ parent ☐ guardian ☐ other _____

I authorize the release of any information concerning my (or my child's) healthcare, to expedite insurance payment. I also hereby authorize payment of insurance and understand that I am responsible for all charges, regardless of insurance coverage.

Patient/ Parent/ or Legal Guardian Signature _____ Date _____

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MEDICAL HISTORY

REASON FOR YOUR VISIT TODAY: ☐ Annual Exam ☐ Eye Problem, which eye: Right / Left
☐ Other: _____

MEDICAL HISTORY

Please check all that apply:

☐ Cancer	☐ Migraines	☐ Heart Disease	☐ Acid Reflux	☐ Diabetes Type 1
☐ Cerebral Palsy	☐ Multiple Sclerosis	☐ Asthma	☐ Arthritis	☐ Diabetes Type 2
☐ Stroke	☐ Bipolar Disorder	☐ Emphysema	☐ Fibromyalgia	☐ Muscular Dystrophy
☐ Tumor	☐ Depression	☐ Hypertension	☐ Osteoporosis	☐ Thyroid Disease
☐ Epilepsy	☐ Attention Deficit	(High Blood Pressure)	☐ High Cholesterol	☐ Environmental Allergies

☐ Other: _____

MEDICATIONS

(Please list all current medications, including eye drops and non-prescription medications)

_____ _____ _____

_____ _____ _____

_____ _____ _____

DRUG ALLERGIES

Please list all drug allergies: _____

_____

OCULAR HISTORY

Do you wear glasses? ☐ YES ☐ NO Do you wear contacts? ☐ YES ☐ NO

Have you ever been diagnosed as having any of the following (check all that apply):

☐ Retinal Detachment	☐ Macular Degeneration	☐ Cataracts
☐ Glaucoma	☐ Keratoconus	☐ Strabismus (crossed eyes)
☐ Amblyopia (lazy eye)	☐ Retinal Hole	☐ Dry Eyes
☐ Retinal Degeneration		

☐ Eye Injury, please explain: _____

☐ Eye Surgery, specify type & date: _____

FAMILY MEDICAL HISTORY

Has any member of your family ever had (check all that apply)

☐ Thyroid ☐ Diabetes ☐ Hypertension

☐ Other: _____

FAMILY OCULAR HISTORY

Please note any family member (living or deceased) having any of the following conditions:

	Family Member		*Family member*
☐ Retinal Detachment	_____	☐ Glaucoma	_____
☐ Macular Degeneration	_____	☐ Strabismus/Amblyopia	_____

☐ Other _____

SOCIAL HISTORY

Do you consume alcohol? ☐ No ☐ Yes If yes, amount? (social, occasional, daily): _____

Do you use tobacco products? ☐ No ☐ Yes If yes, ☐ cigarettes ☐ cigars ☐ pipe ☐ smokeless tobacco ☐ other

Smoking Status: ☐ Never smoked ☐ Former smoker ☐ Current, occasional ☐ Current, everyday

Please list hobbies: _____

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Quincy, IL
195 South 36th St 62301
(217) 224-SPECS (7732)

Carthage, IL
514 Wabash Ave 62321
(217) 357-9750

Mt. Sterling, IL
110 W Main 62353
(217) 773-2100

myspecsquincy.com

CONSENT TO USE OR DISCLOSE HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

Patient name _____

Patient address _____

Patient phone number _____

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, obtain payment for our services, and to conduct health care operations involving our office.

We have a comprehensive Notice of Privacy Practices that describes these uses and discloses in detail. You are free to refer to this Notice at any time before you sign this consent document. As described in our Notice of Privacy Practices, the use and disclosure of your health information for treatment purposes not only includes care and services provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; our submission of your health information to auditors hired by third-party payers and insurers, among other aspects of payment described in our Notice of Privacy Practices. Our Notice of Privacy Practices will be updated whenever our privacy practices change. You can get an updated copy here at the office or from our Web site.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services, and to perform health care operations. You can revoke this consent in writing at any time unless we have already treated you, sought payment for our services, or performed health care operations in reliance upon our ability to use or disclose your health information in accordance with this consent. We can decline to serve you if you elect not to sign this consent form.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or health care operations, but as described in our Notice of Privacy Practices, we are not obligated to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us.

I HAVE REVIEWED, UNDERSTAND, AND AGREE TO THE CONTENT OF THE NOTICE OF PRIVACY PRACTICES AND THIS CONSENT. I CONSENT TO THE USE AND DISCLOSURE OF MY HEALTH INFORMATION FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.

_____ _____

Patient/Personal Representative Signature Date

If you are signing as a personal representative of the patient, please note your relationship as the source of the authority to sign this form

Print Name: _____ Relationship: _____