FISHER GENTRY
EYE CARE

PATIENT INFORMATION SHEET

Patient Name: _____ Date of Birth: _____ Please Circle: Male / Female

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone (____) _____

E-Mail: _____ **Preferred Contact (please circle)** HOME CELL WORK E-MAIL

If you have medical and vision coverage it may be necessary to bill some services to one plan and other services to the other plan. We use coordination of benefits to do this properly and to minimize your out-of-pocket expense.

Insurance Plan: _____ **Vision Plan: _____**

Policy Holder Name: _____ **Policy Holder Date of Birth**: _____

Policy Holder Social Security #: _____-____-_____

Government/Insurance Required Information (Please Circle)

Primary Language: English Spanish French Other: _____

Race: White/Caucasian Black or African American Native Hawaiian or Pacific Islander

American Indian or Alaska Native Asian Other: _____ Declined to Answer

Ethnicity: Not Hispanic or Latino Hispanic or Latino Unknown Declined to Answer

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Emergency Contact Person: _____ Address: _____

Emergency Contact Phone#: _____ Relationship to Patient: _____

INSURANCE AUTHORIZATION:

I certify that I, and/or my dependent(s) have insurance coverage and assign directly to Fisher-Gentry Eye Care all insurance benefits for services rendered. I understand that I am financially responsible for all charges whether paid by insurance or personally. I authorize the use of my signature on all insurance submissions. If my bill is not paid by insurance, I understand I am responsible for any charges. A $25 fee will be applied to all checks with insufficient funds. I am also aware that should my bill be sent to a collection agency due to failure to pay or arrange payments, a fee of 33% of the total bill will be applied to my balance.

Fisher-Gentry Eye Care may use my health care information and may disclose such information to the insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. I further consent to the disclosure of my health information in order for another provider or health care professionals. I consent to allow Fisher-Gentry Eye Care to obtain my previous records from other health care providers if deemed necessary for my care.

I further acknowledge that Fisher-Gentry Eye Care has made available to me a copy of its Notice of Privacy Practices, which provides a detailed description of the uses and disclosures allowed by this consent, as well as other rights I have regarding my protected health information.

Signature: _____ Date: _____Relationship to Patient: _____

(Over Please)

NEW PATIENT EXAMINATION/MEDICAL HISTORY

Reason for today's visit: _____

Date of Last Eye Exam: _____ Name of Previous Eye Doctor: _____

Do you wear Contact Lenses? Yes No Brand/Type of Contact Lenses: _____

Prescription (if known) R: _____ L: _____

Have **you** ever had any of the following?			Which Eye?		Date(s)
• Cataract Surgery	Yes	No	Right	Left	_____
• Laser Surgery	Yes	No	Right	Left	_____
• Retina Detachment	Yes	No	Right	Left	_____
• Glaucoma	Yes	No	Right	Left	_____
• Eye Injury	Yes	No	Right	Left	_____
• Lazy or Turned Eye	Yes	No	Right	Left	_____

Primary Care Physician: _____

Do you have any of the following?

Diabetes:	Yes	No	Family History	Please List Current Medications
High Blood Pressure:	Yes	No	Family History	_____
Endocrine (Thyroid Disease):	Yes	No	Family History	_____
Heart Problems (Irregular, CHF):	Yes	No	Family History	_____
Breathing Problems (Asthma, COPD):	Yes	No	Family History	_____
Gastrointestinal Problems (Reflux):	Yes	No	Family History	_____
Kidney Problems:	Yes	No	Family History	_____
Arthritis:	Yes	No	Family History	_____
Neuro Problems (Seizure, Migraine):	Yes	No	Family History	_____
Mood Disorders (Depression, Anxiety):	Yes	No	Family History	
Blood Disorders (Anemia, Sickle Cell):	Yes	No	Family History	
HIV/AIDS	Yes	No	Family History	
Cancer (Type:_____)	Yes	No	Family History	Please List Any Allergies
Are you pregnant?	Yes	No		_____
Do you smoke?	Yes	No		_____
Do you drink alcohol?	Yes	No		_____

How did you hear about our office? Newspaper Yellow Pages Website Word of Mouth Screening

Other_____