WELCOME FORM

Name: _____ Today's Date: _____/_____/_____

Address: _____
(number) (street) (city) (state) (zip)

Home Phone:(_____)_____ Cell Phone:(_____)_____ email:_____

Birth Date: _____/____/_____ Age: _____Occupation: _____ Social Security #: _____/_____/___ ___

Name of Medical Doctor: _____ DR's Address: _____

Last Medical Exam: _____/_____/_____Doctor's Phone #: (_____)_____ _____

Vision Insurance_____ ID#: _____ Group #: _____

Medical Insurance_____ ID#: _____ Group #: _____

Under whose name? _____ **Who may we thank for referring you to us?**_____

Why are you here today? _____

My last eye exam was _____ years ago in (city)_____E-mail_____

Medical History

Do you have any allergies to medications? no yes If yes, explain: _____

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies):_____

_____

_____

Acknowledgment of Receipt of Notice of Privacy Practices

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, to obtain payment for our services, and to conduct healthcare operations involving our office. The *Notice of Privacy Practices* you have been given describes these uses and disclosures in detail.

I acknowledge that I have received the *Notice of Privacy Practices* from Visual Eyes

Signature_____ **Date**_____

If signing as a personal representative of the patient, describe the relationship to the patient and source of authority to sign this form.

Relationship:_____ Print name:_____

Insurance Acknowledgment

INSURANCE POLICY: I understand that all deductibles and charges not covered by my insurance will be fully paid by me.

Signature _____ **Date**_____