Hoover Vision Center, P.C.

PATIENT INFORMATION

(Please Print)

Date: ____/____/____ New _____ Update _____

Last name _____ First name _____ Middle _____

Preferred name _____ Date of Birth ____/____/_____ Age _____ Sex: *M / F*

Social Security _____ - ___ - _____ Drivers License # _____ Marital Status: *S / M / W / D*

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Other Phone _____ Email _____

Preferred Contact: *Home Phone / Cell Phone / Work Phone / Email / Regular Mail*

Preferred Language: *English / Spanish /* _____ Ethnicity: *Hispanic/Latino // Not Hispanic/Latino*

Race: *American Indian or Alaskan Native / Asian / Black or African American*
Native Hawaiian or Pacific islander / White

Occupation _____ Status: *Employed / Retired / Unemployed / Disabled*

Employer _____ If Student: Grade _____ School _____

Who referred you to this office ? _____

Please list any family members who are patients of this office.

Name	Relation	Age

Emergency Contact _____ Phone _____ Relationship _____

Insurance Information

Primary *(medical)* _____ Policy # _____ Group # _____

Insured Name: _____ Insured DOB _____

Secondary *(medical)* _____ Policy # _____ Group # _____

Insured Name: _____ Insured DOB _____

Vision Plan _____ Policy # _____

Insured Name: _____ Insured DOB _____

Please have insurance cards and drivers license available for receptionist to copy

Please turn this form over and complete side two

Financial Information

Is patient responsible for bill? Yes / No If not, complete the following information:

Guarantor: Last name _____ First name _____

DOB _____/_____/_____ Social Security # _____

Address _____

Home phone _____ Work Phone _____

Employer _____ Relationship _____

Note: Minors must be accompanied by an adult for examination and when picking up materials.

Collection Policy

Our doctors participate in a variety of insurance plans. As a courtesy to our patients, we will be happy to file most claims. You will be expected to pay your co-pay, deductible, and any non-covered service at each visit. For example, refractions, which are a necessary component of an eye exam, are not covered by Medicare. *If your insurance requires a referral, it is your responsibility to contact your primary care physician and obtain the referral number and any other necessary information*. If you have any questions about your insurance or account, please feel free to contact our insurance and billing coordinator.

I authorize the release of any medical information necessary to process a claim on any insurance policy listed above. I hereby assign to and authorize payment directly to Hoover Vision Center. P. C. for all benefits payable under such insurance policy. I realize that the insurance benefits may not pay all of the bill, and I agree to pay the difference or the entire bill if necessary. In the event of default in the payment of my charges, I agree to pay all cost of collection, including a reasonable attorney's fee, should the account be referred to an attorney for collection. I further agree to waive my rights of exemption as to personal property.

I understand that a finance charge of 1.5% per month shall be added to all balances over 30 days.

I have read the above policies and agree as indicated by my signature.

_____ _____

Patient or Responsible Party Signature **Date**

Medical History Questionnaire

(Please Print)

Name: _____ Date: ____/____/_____ Date of Birth: ____/____/_____

Last medical exam: ____/____/_____ Medical Doctor (name,location):_____

Last eye exam: ____/____/_____ Last Eye Care Provider:_____

Pharmacy (name, location, phone):_____

Past Eye History

Have you ever had any eye injuries? ☐ No ☐ Yes: (list)_____

Have you ever had any eye surgeries? ☐ No ☐ Yes (list)_____

List any eye drops you use :_____

Do you wear glasses? ☐No ☐Yes / How old is you present pair of lenses?_____

Do you wear contact lenses? ☐No ☐Yes / How old is your present pair of lenses?_____

Type of contact lenses: ☐Rigid ☐Soft Wearing Schedule: ☐Remove daily ☐Sleep in lenses

How often do you throw away your lenses? _____ Are your lenses comfortable? _____

Do you have or ever had any of the following eye conditions or diseases? Please check all that apply.

☐ Cataracts ☐ Glaucoma ☐ Macular Degeneration ☐ Retinal Detachment/ Disease ☐Dry Eyes ☐ Eye Infections

☐Loss of Vision/Side Vision ☐ Itchy Eyes ☐Double Vision ☐Blurred Vision ☐Flashes/Floaters ☐ Crossed Eyes

☐Lazy Eyes ☐Drooping Eyelid ☐Other _____

Past Medical History

List all medications:_____

_____

_____

Allergies: ☐None ☐ Yes(list)_____

List all major injuries, surgeries and / or hospitalizations you have had: _____

_____

Are you pregnant ? ☐No ☐Yes / Weeks _____ Are you Nursing? ☐No ☐Yes

Do you have any medical conditions? Please check all that apply. ☐Diabetes ☐ High Blood Pressure ☐Heart Disease ☐High Cholesterol ☐Thyroid Disorder ☐Autoimmune Disease (name:_____) Please list any additional medical conditions._____

_____

Family History: (Check all that apply to your blood relatives)

☐Blindness ☐Glaucoma ☐Macular Degeneration ☐Cataracts ☐Lazy Eye ☐ Retinal Disease/Detachment ☐Diabetes ☐Heart Disease ☐Stroke ☐ High Blood Pressure ☐Arthritis ☐Kidney Disease ☐Thyroid Disorder ☐Autoimmune ☐Other _____

Social History

Smoking Status: ☐ Current every day smoker ☐Current some day smoker ☐Former Smoker ☐Never smoked

☐Smoker, current status unknown ☐ Unknown if ever smoked

If smoker: How much?_____ How long? _____ When quit? _____

Alcohol Use: ☐None ☐ Occasional drinker ☐Everyday drinker Type_____ How long?_____

Drugs: ☐No ☐Yes: type/amount/how long: _____

Check if you have ever been exposed to or infected with: ☐ Gonorrhea ☐ Syphilis ☐ HIV ☐Hepatitis

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