Personal Information

Please print

Name_______________________________________ Date ______________________________

Date of Birth ______/______/______ Age________M/F______ Social Security_______________________

Address____
Street City State Zip

PO Box (if applicable)____

Phone: Home (______) ___________________________ Cell (______) ___________________________

Email ____

Employer______________________________________ Occupation_________________________

Work Address ___________________________________ Work Phone (_____)____________________

Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Ethnicity: ☐American Indian ☐Asian ☐African American ☐Native / Hawaiian ☐White ☐ Latino ☐Declined to specify

Language: ☐ English ☐ Spanish ☐ Other______________________

Spouse Name _________________________________ Employer ________________________________

Spouse Date of Birth ______/______/______ Address____

Complete if under 18 years old

Name of Father:_______________________________________ Date of Birth _______/_______/_______

Employer: __________________________ Address:____

Phone: Home (______) ___________________________ Cell (______) ___________________________

Name of Mother:_______________________________________ Date of Birth _______/_______/_______

Employer: __________________________ Address:____

Phone: Home (______) ___________________________ Cell (______) ___________________________

Pharmacy

Pharmacy Name____________________ Address:____

Primary Dr.

Primary Doctor_____________________________________ Address____________________________

Referral Information

Referred by: ☐ Friend / Relative _____________________ ☐ Doctor ___________________________
Name Name

☐Facebook / Google ☐Other ____

Emergency Contact

Who to notify in an emergency (nearest relative or friend)?

Name ____ Relationship_________________________

Address____
Street City State Zip

Phone: Home (______) ___________________________ Cell (______) ___________________________

Authorization to Release Confidential Information: By signing below, I authorize the Southwest Eye Institute to disclose information and records regarding my medical condition(s) and medical and surgical treatment(s) to my other health-care providers and to my insurance carrier(s), including to any potential future healthcare provider(s) regardless of whether or not I have an established relationship with them.

Consent to Photography: As part of my examinations today and in the future, I understand that I may be photographed for medical charting, diagnostic purposes, insurance verification, education, and / or research purposes. By signing below, I give the Southwest Eye Institute and its physicians and staff permission to take photographs for the above listed purposes today and during future visits.

Information Regarding Dilating Eye Drops: Dilating drops are used to enlarge the pupils of the eye to allow your doctor to get a better view of the inside of your eye. Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible to predict how much your vision will be affected. Because driving may be difficult afterwards, you are advised not to drive yourself for 24 hours after your examination today. You also should be careful when walking as it may be harder to see or judge potential hazards. Adverse reactions, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is rare and usually treatable with immediate medical attention. By signing below, I hereby authorize the doctors and/or assistants to administer dilating eye drops. The eye drops may be necessary to diagnose my condition.

Notice Regarding Refraction Fees: I understand that payment for the refraction (eyeglass prescription) portion of a complete eye examination is usually not covered by medical insurance and is my responsibility. The usual charge for this service is $65.00. By signing below, I acknowledge that I may be responsible for the charges related to refraction.

Financial Assignment and Agreement: Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain examinations and procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance. In order to control the cost of billings, we request that your charges for office visits and procedures be paid prior to each visit and/or procedure. Please note that bounced checks will be assessed a $25 fee. Unpaid accounts may be sent to a collection agency.

By signing below, I request that payment of authorized Medicare and /or insurance benefits be made to the Southwest Eye Institute on my behalf for any services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration, its agents, or any insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services. This assignment will remain in effect until revoked by me in writing. A photocopy or scanned copy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment. Furthermore, my signature below acknowledges that I have read a copy of the Privacy Practices Notice from the Southwest Eye Institute.

______________________________	________/________/________
Patient's or Legal Guardian's Signature	Date
______________________________	______________________________
Name (Printed)	Relationship of signee to patient