## *WELCOME, THANK YOU FOR CHOOSING DR. WILLIAM F. HARVEY'S OFFICE.*

**PLEASE PRINT CLEARLY PATIENT INFORMATION AND SIGN** DATE:____________________

Last Name ______________________ First Name ____________________ MI______

Address ______________________ Apt_____ City/State ________________ Zip________

Home phone ______________ Work Phone ______________ Cell Phone ______________

Email Address ____________________________________________

Sex: M F Date of Birth ______________ Marital Status: Single Married Divorced Widow(er)

Social Security Number ____________________________________________

Occupation ______________________ Employer ______________________

Referred by ____________________________________________

Emergency Contact ____________________ Phone Number ____________________

**PRIMARY INSURANCE MEMBER/ PERSON RESPONSIBLE FOR PAYMENT– IF OTHER THAN SELF:**

Last Name ______________________ First Name ____________________ MI______

Address ______________________ Apt_____ City/State ________________ Zip________

Home phone ______________ Work Phone ______________ Cell Phone ______________

Email Address ____________________________________________

Sex: M F Date of Birth ____________________________________________

**Social Security Number** ____________________________________________

Relationship to Patient ____________________________________________

**VISION / MEDICAL INSURANCE INFORMATION**

Vision Insurance ______________________ ID Number ____________________

Member's Name ____________________ Relation: Self Spouse Child Other

Medical Insurance ______________________ ID Number ____________________

Member's Name ____________________ Relation: Self Spouse Child Other

Secondary Insurance ____________________________________________

I'm interested in: ______ Glasses ______ Contact Lenses ______ Laser Correction Surgery

I have a back up pair of glasses: Yes No

Current vision correction: ______ Glasses ______ Contact Lenses ______ Laser/Refractive Surgery

Is there a Specific Reason for your visit? ____________________________________________

**General Health**______________________ **Last Eye Exam**_______________ **Eyes Dilated? Yes No**

| History | Personal | | Family | | History | Personal | | Family | | History | Personal | | Family | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Arthritis | Y | N | Y | N | Kidney Disease | Y | N | Y | N | Glaucoma | Y | N | Y | N |
| Asthma | Y | N | Y | N | Thyroid Disease | Y | N | Y | N | Retinal Detachment | Y | N | Y | N |
| Respiratory | Y | N | Y | N | Anxiety | Y | N | Y | N | Macular Degeneration | Y | N | Y | N |
| Herpes | Y | N | Y | N | Hypertension | Y | N | Y | N | Cataracts | Y | N | Y | N |
| HIV | Y | N | Y | N | Hepatitis | Y | N | Y | N | Dry Eyes | Y | N | Y | N |
| Heart Attack | Y | N | Y | N | Stroke | Y | N | Y | N | Headaches | Y | N | Y | N |
| Cancer | Y | N | Y | N | Diabetes | Y | N | Y | N | Blurred Vision | Y | N | Y | N |
| | | | | | | | | | | Cholesterol | Y | N | Y | N |

If yes, type of cancer: ______________________________

Allergies Yes No (list) including any allergies to medicine______________________________

__________________________________________________________

Other health problems______________________________________________

List any medications you are taking _______________________________________

__________________________________________________________

__________________________________________________________

Are you pregnant and/or nursing? Yes No

Have you had any eye operations including laser eye correction (such as Lasik) Yes No

Date/Type______________________________

Have you had an eye injury? Yes No Date/Type______________________________

Do you use? Cigarettes/Tobacco Yes No Alcohol Yes No Other Substances Yes No

Primary Care Doctor/Provider____________________________Date of last visit____________________

I understand that payment for the goods or services I will receive is expected at the time that they are rendered. A deposit, If unable to make full payment, is required for glasses or contact lenses ordered. Any order cancellations done after completion of the job will result in the loss of deposit. Any materials not dispensed within 90 days of completion and notification may be returned to stock and are subject to loss of deposit. Any missed appointments not canceled 24 hours prior to appointment will result in a fee of $25.00.

I,______________________________hereby, agree to be financially responsible for all charges incurred over and above the amount allotted by insurance coverage. In the event my account is referred to a collection service due to the lack of payment on my part, I agree to pay all collection agency/legal fees that may be added to my account.

Returned checks: A $25.00 NSF fee will be charged for checks initially returned unpaid by your bank. If the same check is returned unpaid a second time, it may be referred to a collection service for recovery.

I have read and understand all the above conditions, and agree to their terms.

I acknowledge that I have received a copy of the **Notice of Privacy Practices** for the office of William F. Harvey, O.D., Inc.

**Insurance Signature on File:** I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping obtain payment of my insurance and/or Medicare benefits, and I authorize payment of these benefits directly to William F. Harvey, O.D., Inc. on my behalf for any services and materials furnished. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits payable to related services. If I have other health insurance coverage (as indicated in item 9 or the CMS-1500 claim form or electronically submitted claim.) my signature authorizes release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as my agent as above. I will be responsible for any co-payments and payments for non-covered services. My signature below indicates that I understand and accept all office policies.

____________________________________ ______________________

**Signature** (Parent or Guardian if under 18) Date