Treasure State Eyecare Center

Dr. Joe Vincent
Dr. Justine Redlin

Patient's Name _____
FIRST MIDDLE LAST
Age_____ Sex_____Date of Birth_____Patient's Social (SSN)# _____/____/_____
Mailing Address_____City_____
Street Address
State_____Zip Code_____ Res. Phone ( ) _____
Occupation/Employer_____ Business Phone ( ) _____

Marital Status (Circle) Single Married Separated Divorced Widowed

Primary Vision Insurance_____ ID #_____ Grp#
Secondary Vision_____ ID#_____ Grp#
Responsible Party _____DOB_____ SSN# _____/_____/_____

Primary Medical Insurance_____ ID #_____ Grp#
Secondary Medical_____ ID#_____ Grp#
Responsible Party_____DOB_____ SSN#_____/____/_____

Treasure State Eye Care offers the ability to conveniently send appointment reminders, notify you of glasses and contact lens orders ready to be picked up, and allow you the ability to communicate efficiently with our office via text messages and E-Mail. The following information will only be used by this office for official business, will not be sold to marketers, and can be opted-out of at any time.

E-Mail Address:_____ Cell Phone: _____

Has any member of your immediate family been a patient of Treasure State Eye Care Center? If yes, please name: _____

How were you referred to our office? Friend/Family: _____
Yellow Pages Newspaper Sign Internet Facebook
Please circle your preferred method of payment.
Cash Check Credit Card Debit CareCredit Other
Payment is expected at the time services are provided.

Most insurance companies pay only a portion of your total charges. If you have any questions on coverage, please contact your representative. We can not guarantee the accuracy of benefit information given to us by the insurance company. Please understand that the financial responsibility of your account is yours, not your insurance company's. I authorize the release of any medical or other information necessary to process insurance claims. I authorize payment of medical or vision benefits to the practitioner or supplier of services rendered or myself if the provider does not accept assignment. I understand that I am responsible for any balance that my insurance does not pay.
I understand that should I default on payment of my account and collection agency services are required, all costs of collections up to 40% of the balance, including attorney/court costs will be added to the balance of my account.

Signed: _____ Parent/Guardian: _____ Date:_____

So that we can provide you with the most thorough eye examination and better serve your visual needs, we would appreciate you taking a few minutes to answer the following questions:

Main reason for visit to us today _____
Do you currently wear contact lenses? Y or N
If not, are you interested in trying them? Y or N
Do you use a computer more than 30 minutes/day? Y or N

PERSONAL OCULAR HISTORY

Please indicate with an (x) if yes, leave blank if no.

___ Eye pain
___ Double vision
___ Glaucoma
___ Floaters/Flashes of light
___ Watering eyes
___ Blurred vision at near
___ Blurred vision at far
___ Cataracts
___ Dry Eyes
___ Macular degeneration
___ Eye injuries
___ Eye infections
___ Eye Surgery
___ Burning eyes
___ Other

PERSONAL HEALTH HISTORY

___ Diabetes
___ Skin problems
___ Epilepsy
___ Heart attack/stroke
___ Headaches
___ High blood pressure
___ Anxiety/Depression
___ Cancer
___ Arthritis
___ Thyroid trouble
___ Heart disease
___ Respiratory Issues
___ Allergies
___ GI issues
___ Anemia
___ Other

Confidential information required by health insurance: **Height**_____ **Weight**_____

FAMILY HISTORY

___ Diabetes
___ Thyroid trouble
___ Glaucoma
___ Blindness
___ High Blood Pressure
___ Heart attack/stroke
___ Macular degeneration
___ Color blindness
___ Heart disease
___ Cancer
___ Crossed Eyes
___ Cataracts

Approximate date of last eye exam_____ Doctor _____
Do you have a Primary Care doctor?_____Doctor _____

Are you currently taking any prescription drugs, including birth control pills? Yes ____ No ____
If yes, **please list**_____
Any known medical allergies: **Y** or **N** Please list medications _____

Do you currently smoke? **Y** or **N** If yes: Packs per day:_____ How many years? _____
Drink alcohol? **Y** or **N** Recreational drugs? **Y** or **N**

Hobbies _____

Acknowledgment of Receipt of Privacy Practices
I acknowledge that I received a copy of Dr. Vincent/Dr. Redlin OD "Notice of Privacy Practices."

Signed _____ Date _____
Patient Name (printed)_____