



Are you here for: **Glasses exam** \_\_\_\_\_ **Contacts** \_\_\_\_\_

**Other Reason** \_\_\_\_\_

**Name** \_\_\_\_\_

**Male** \_\_\_\_\_ **Female** \_\_\_\_\_

**Address** \_\_\_\_\_

**Date of Birth** \_\_\_\_\_

**City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_

**List ALL insurances** \_\_\_\_\_

**How much is your co-pay?** \_\_\_\_\_

Are you the Primary Insured or are you a family member? \_\_\_\_\_

**Primary** \_\_\_\_\_ **Family member (spouse / child)** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_

**Cell Phone:** \_\_\_\_\_

**Email:** \_\_\_\_\_

***Which of our offices was your last appointment?***

Skibo / Hope Mills / Raeford / Ramsey / Yopp

Marine / Hendersonville / Ft. Bragg / Other

**Office Name:** \_\_\_\_\_



We're **online!** **Confirm** your appointments via text or email! Your **email** is the only way we will send you a yearly reminder (not for soliciting)

**I know my HIPAA rights:** \_\_\_\_\_ Yes

**Personal Medical** **Race:** \_\_\_\_\_

**Family Doctor** \_\_\_\_\_ ( \_\_\_\_\_ Never \_\_\_\_\_ Don't remember) **Last Visit:** \_\_\_\_\_

**Last Eye Doctor** \_\_\_\_\_ ( \_\_\_\_\_ Don't have one) **Last Eye Exam** \_\_\_\_\_

What problems are you having today (check all that apply):

Are these problems noticed with your glasses / contact on or off? \_\_\_\_\_ **On** \_\_\_\_\_ **Off** \_\_\_\_\_ **Both**

<u>What</u>	<u>Location</u>	<u>Duration</u>	<u>Timing</u>	<u>Context</u>	<u>Severity</u>
___ Blur at distance	___ Both eyes	___ Minutes	___ Constant	___ While driving	___ Mild
___ Blur at near	___ Right eye	___ Hours	___ Intermittent	___ School board	___ Moderate
___ Blur everywhere	___ Left eye	___ Days		___ Reading book	___ Severe
___ Diabetic Ret.		___ Months		___ Computer	
___ Glaucoma		___ Years		___ Other	
___ Macular Degen		___ All my life			
___ Cataract					
___ Dry					
___ Itch					
___ Pain					

**Does anything make it better?** **No** \_\_\_\_\_ **Yes, what?** \_\_\_\_\_

Other information you wish to provide:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



## **Waiver of Insurance Claim**

I, \_\_\_\_\_, understand that by signing this form I am waiving my right to use any insurance I may have to cover the procedures today. My charges will not be billed to my insurance company, and I will not receive credit towards my deductible if need apply. I also understand that since I am declining to use my insurance, payment is due at the time services are rendered.

**Patient's Name (print)** \_\_\_\_\_

**Patient's Signature** \_\_\_\_\_

**Date** \_\_\_\_\_

**Staff Signature** \_\_\_\_\_