Welcome to Hamilton Vision & Eye Care

Please fill in completely the following patient information, and then sign and date on the back of the form. If you need assistance, please speak to our Front Desk Staff.

Patient Information

Name:_____ **Birthdate:**____/____/____

Address:_____ **Social Security Number:**____-____-____

City, State & Zip:_____ **Sex:** ☐**Male** ☐**Female**

Home Phone: (____) ____-____ **Marital Status:** ☐**Married** ☐**Single** ☐**Divorced**

Cell Phone: (____) ____-____ ☐**Widowed** ☐**Other**

Other Phone: (____) ____-____ ☐**Work** ☐**Spouse** **Email Address:**_____

Preferred Contact: ☐**Home Phone** ☐**Cell Phone** ☐**Other Phone** ☐**Email** ☐**Regular Mail**

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

Race: ☐**American Indian or Alaska Native** ☐**Asian** ☐**Black or African American**
☐**Native Hawaiian or Other Pacific Islander** ☐**White**

Occupation: _____ **Employer:**_____

Status: ☐**Employed** ☐**Retired** ☐**Unemployed** **Address:**_____

City, State & Zip:_____

Phone: (____) ____-____ ☐**Work** ☐**Home** ☐**Cell**

Guarantor Information

☐***If same as patient, check here.***

Name:_____ **Birthdate:**____/____/____

Address:_____ **Social Security Number:**____-____-____

City, State & Zip:_____ **Sex:** ☐**Male** ☐**Female**

Home Phone: (____) ____-____ **Relation to Patient:** ☐**Spouse** ☐**Child**

Other Phone: (____) ____-____ ☐**Work** ☐**Cell** ☐**Spouse** ☐**Other**_____

Other Phone: (____) ____-____ ☐**Work** ☐**Cell** ☐**Spouse** **Email Address:**_____

Occupation: _____ **Employer:**_____

Status: ☐**Employed** ☐**Retired** ☐**Unemployed** **Address:**_____

City, State & Zip:_____

Phone: (____) ____-____ ☐**Work** ☐**Home** ☐**Cell**

Insurance Information

Primary Insurance:_____ **Insured Name:** _____

Policy or ID#:_____ **Group #:**_____ **Insured DOB:**____/____/____

Group Name (as shown on insurance card):_____ **Copay: $**_____

Secondary Insurance:_____ **Insured Name:** _____

Policy or ID#:_____ **Group #:**_____ **Insured DOB:**____/____/____

Group Name (as shown on insurance card):_____ **Copay: $**_____

Referred By:_____ **Reason for Appointment:**_____

Emergency contact:_____ **Phone:** (____) ____-____ **Relationship:**_____

Are you currently under the care of a hospice program? ☐**Yes** ☐**No**
(Staff: If "Yes", indicate "Hospice Program" in Patient Alert Note – Centricity)

PLEASE TURN PAGE OVER AND SIGN. THANK YOU>>>>

Signature on File, Assignment of Benefits, Financial Agreement

Beneficiary Name *(print)* Medicare Number

1. **MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to __(PRACTICE)__, for services furnished me by __(PRACTICE)__. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. __(PRACTICE)__ accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and noncovered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

2. **MEDIGAP:** I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to __(PRACTICE)__, if possible or otherwise to me.

3. **RELEASE OF INFORMATION:** __(PRACTICE)__ may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to __(PRACTICE)__ for reimbursement for services rendered, and (2) any health care provider for continued patient care. __(PRACTICE)__ may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute or regulation. A copy of this authorization may be used in place of the original.

4. **OTHER INSURANCE:** I understand that __(PRACTICE)__ maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office. And that __(PRACTICE)__ has no contract, expressed or implied, with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by __(PRACTICE)__ if I belong to a plan that does not appear on the above mentioned list.

5. **NON-COVERED SERVICES:** I understand that __(PRACTICE)__'s contracts with health care service plans (i.e., HMOs, PPOs) relate only to items and services which are "covered" by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient; and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with __(PRACTICE)__ to obtain necessary health care service plan authorizations.

6. **FINANCIAL AGREEMENT:** I agree that in return for the services provided to the patient by __(PRACTICE)__, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to __(PRACTICE)__ for payment. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to __(PRACTICE)__. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to __(PRACTICE)__. *However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.*

Beneficiary Signature or Authorized Party Date

Medical History Questionnaire

Name:_____ Date: ___/___/_____ Birth Date: ___/___/_____
Last Medical Exam:___/___/_____ Name of Medical Doctor:_____ Dr.'s Phone:_____
Name of Pharmacy:_____ Pharmacy Number:_____
Last Eye Exam:___/___/_____ Name of Eye Care Provider:_____

Past Eye/Medical History

Allergies: ☐None ☐Yes: (list)_____
Have you ever had any eye injuries? ☐No ☐Yes: (list)_____
Do you have any eye diseases? ☐No ☐Yes: (list)_____
Have you ever had any eye surgeries? ☐No ☐Yes: (list)_____
Do you currently use any eye medications? ☐No ☐Yes: (list)_____
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. _____
_____
_____
List all major surgeries:_____
_____
List all medications:_____
_____
_____

Are you pregnant or nursing? ☐No ☐Yes
Check if you have ever been exposed to or infected with: ☐Gonorrhea ☐Syphilis ☐HIV ☐Hepatitis ☐TB
Do you wear glasses? ☐No ☐Yes If yes, how old is your present pair of lenses?_____
Do you wear contact lenses? ☐No ☐Yes If yes, how old is your present pair of lenses?_____
Type of contact lenses: ☐Rigid ☐Soft ☐Extended Wear ☐Other

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

☐Diabetes	☐Stroke	☐Blindness	☐Macular Degeneration	☐Arthritis
☐Cancer	☐TB	☐Cataracts	☐Retinal Disease	☐Lazy Eye
☐Heart Disease	☐Kidney Disease	☐Glaucoma	☐High Blood Pressure	Other:_____

Social History:

Smoking Status: (Check one) ☐Current every day smoker ☐Current some day smoker ☐Former smoker
☐Never smoked ☐Smoker, current status unkown
☐Unknown if ever smoked
If smoker: How much? _____ How long? _____ When quit? _____
Alcohol Use: ☐No ☐Yes: Type? _____ How much? _____
Drugs: ☐No ☐Yes: Type? _____ How much? _____ How long? _____ When quit? _____