THE OPTICAL CENTER AND HEARING CENTER

Patient Information:

First Name:_____ Last Name:_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Cell :_____ Work Phone :_____

SSN:_____ Sex:_____ Birthdate:_____ Marital Status:_____

Occupation:_____ Age:_____

Responsible Party Information: (if different from above)

First Name:_____ Last Name:_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone:_____ Cell:_____

SSN:_____ Sex:_____ Birthdate:_____ Marital Status:_____

Insurance Information:

Primary Insurance Company: _____

Subscriber Name:_____ ID Number:_____

Address:_____ City:_____ State:_____ Zip:_____

Group Number:_____ Relationship to Insured:_____

Secondary Insurance Company: _____

Address:_____ City:_____ State:_____ Zip:_____

Subscriber Name:_____ ID Number:_____

Group Number:_____ Relationship to Insured:_____

***** YOU are responsible for providing correct and complete insurance information *****

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or depends. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependants, and that I will be bound by this signature as though the undersigned had personally signed the particular claim:

I _____ hereby authorize _____ to pay and hereby assign directly to
(Name of Insured) (Name of Insurance Company)

Custom Eye RX/S all benefits, if any, otherwise payable to me for his/her services as described on the attached forms. I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to **Custom Eye RX/S** will be credited to my account, in accordance with the above said assignment. I further understand that I will incur a $25 No Show charge if I do not notify **Custom Eye RX/S** that I can not make my scheduled appointment.

_____ _____
(Authorized Signature of Subscriber) (Date)

***** Please make a copy (front and back) of all insurance cards and attach to this document *****

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MEDICAL INFORMATION

☐ **New Patient** ☐ **Annual Exam** ☐ **Emergency** ☐ **Worker's Comp**

MEDICATIONS: *List all medications you are taking.* ☐ None

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

ALLERGIES; *List medications to which you're allergic and what type of reaction you had* ☐None

1. _____ Reaction: _____
2. _____ Reaction: _____

EYE PROBLEMS: *Please check the following Eye Problems you have.*

YES	NO		
☐	☐	**Decreased Vision**	☐ **Difficulty Driving?** ☐ **Daytime Driving** ☐ **Night time**
☐	☐	**Red Eyes or Dry Eyes**	
☐	☐	**Eye Pain or Irritation**	**How Old Are Your Glasses:** _____
☐	☐	**Double Vision**	
☐	☐	**Flashes of Light**	☐ **Eye Injury? Type**_____ **Date**_____
☐	☐	**Floaters**	☐ **Eye Surgery?**
☐	☐	**Halos around Lights**	_____**Date:**_____**By Dr.**_____
☐	☐	**Lazy Eye**	_____**Date:**_____**By Dr.**_____
☐	☐	**Glaucoma**	
☐	☐	**Known Eye Disease? Type:**	_____

MEDICAL PROBLEMS; *Please check the following Medical Problems you have:*

YES	NO		
☐	☐	**Diabetes Mellitus**	**Treated by:** ☐ **Diet Only** ☐ **Oral Pills** ☐ **Insulin** ☐ **Years?** _____
☐	☐	**Asthma**	
☐	☐	**Heart Problems**	☐ **Other Problems?** _____
☐	☐	**High Blood Pressure:** _____	☐ **Trouble hearing doorbell ring or understanding speech**
☐	☐	**Arthritis – Type:**_____	☐ **Complain about hearing conversations or television**
☐	☐	**Recent Surgery: - Type & Date:**	_____

FAMILY HISTORY; *Please check the Medical Problems in your family:*

YES	NO		YES	NO		YES	NO	
☐	☐	**Diabetes**	☐	☐	**Glaucoma**	☐	☐	**Other Problems:**
☐	☐	**High Blood Pressure**	☐	☐	**Crossed Eyes**			_____
☐	☐	**Heart Disease**	☐	☐	**Retinal Detachment**			_____
☐	☐	**Arthritis**	☐	☐	**Macular Degeneration**			_____

MEDICAL DOCTOR: *Who is your Primary Care Physician:* _____

Patient:_____ **DATE:**_____

(FIRST NAME) (MIDDLE I.) (LAST NAME)