

<p>Patient Information</p> <p>Patient Name _____</p> <p>Address _____</p> <p>City _____ Zip _____</p> <p>Hm Ph _____ Wk/Cell Ph _____</p> <p>Email _____</p> <p>Sex <input type="checkbox"/> M <input type="checkbox"/> F Age _____ Birth date _____</p> <p>Patient SSN# _____</p> <p><input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced</p> <p>Employer _____ Ph _____</p> <p>Spouse Name _____</p> <p>Birth date _____ SS# _____</p> <p>Spouse's Employer _____ Wk Phone _____</p> <p>Emergency Contact _____</p> <p>Phone _____ Relationship _____</p> <p>Whom may we thank For referring you? _____</p> <p>About when was your Last Eye Exam _____</p> <p>Do you have difficulty seeing at a distance? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you have difficulty focusing at near? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you have trouble with glare at night? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you wear sunglasses? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are you interested in contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are you interested in colored contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you have vision problems with computer use? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Insurance</p> <p>Responsible Party if other than patient? (Primary insured) Name _____</p> <p>Relationship to Patient (circle) Self Spouse Parent</p> <p>Insurance Co. _____ group# _____</p> <p>SSN/ID # _____ Insured's DOB _____</p> <p>Primary Care Physician _____</p> <p>Medical Group _____ Ph. # _____</p> <p>Is patient covered by additional Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Insurance Co. _____ group# _____</p> <p>Subscriber (2nd. Insured) _____</p> <p>SSN/ID # _____ Insured's DOB _____</p> <p>Relationship to Patient (circle) Self Spouse Parent</p> <p>Assignment & Release</p> <p>I, the undersigned certify that I (or my dependant) have insurance coverage with above listed insurance company and assign directly to Dr. Michael Johnson, O.D., all insurance benefits, if any, otherwise payable to me for services rendered. In addition, understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions. Additionally, I understand that I am responsible for 100% of all collection charges, and that a \$20 fee shall be assessed for any returned check.</p> <p>X _____</p> <p>Responsible Party Signature Date</p>
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<p>Medications</p> <p>List all current medications including any eye drops:</p> <p>1. _____ 6. _____</p> <p>2. _____ 7. _____</p> <p>3. _____ 8. _____</p> <p>4. _____ 9. _____</p> <p>5. _____</p>	<p>Health Conditions</p> <p>Heart or vascular disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Asthma or lung disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Gastrointestinal disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Other Medical Condition _____</p>	<p>Allergies</p> <p>List your allergies to any medications:</p> <p>1. _____</p> <p>2. _____</p> <p>3. _____</p> <p>4. _____</p> <p>5. _____</p>
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<p>Receipt of Notice of Privacy Practices</p> <p>I _____, acknowledge that I have received the notice of Privacy Practices for the practice of Michael Johnson, OD.</p> <p>Signature _____ Date _____</p> <p>of Patient or Guardian X _____</p>

<p>Medicare Authorization (Medicare patients only)</p> <p>I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Johnson for any services furnished me by him. I authorize any holder of medical information about me released to the Health Care Financing Administration and it's 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 or electronically submitted claims. My signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based on the charge determination of the Medicare carrier.</p> <p>Signature _____ Date _____</p> <p>of Beneficiary _____</p>
