Welcome to East Hill Optometry!

To help us take better care of you, please provide us with the following information.

Today's Date ____/____/____ Last Name ____________________

Date of Birth ____/____/____ First Name ____________________

Sex Male / Female Social Security # ____________________

Home Phone (   )   - ________ Address ____________________

Cell Phone (   )   - ________ City/State/Zip ____________________

Email ____

Occupation ________________ Employer ____________________

Emergency Contact Name and Telephone ____________________ (   )   - ________

VISION INSURANCE INFORMATION

Insurance ________________________ ID # ________________________________ Group # ________________

Cardholder Name ______________________________________ DOB __________________________________

MEDICAL INSURANCE INFORMATION

Insurance: ________________________ ID # ________________________________ Group # ________________

Cardholder Name ______________________________________ DOB __________________________________

Do you wear glasses? ☐ Yes ☐ No

Are you interested in glasses? ☐ Yes ☐ No

Do you wear Contacts? ☐ Yes ☐ No

Have you previously worn contacts? ☐ Yes ☐ No

Are you interested in contacts? ☐ Yes ☐ No

MEDICAL HISTORY

Medications you take:

____

Allergies you have:

____

Do you have any of the following?:

☐ Dry Eyes ☐ Eye Pain ☐ Blurred Vision ☐ Eye Injuries ☐ Loss of Vision

☐ Double Vision ☐ Redness ☐ Eye Surgeries ☐ Mucous Discharge ☐ Watering

FAMILY HISTORY *Do you or your family have any of the following? (living or deceased)*

DISEASE/CONDITION	Self	Family	N/A	DISEASE/CONDITION	Self	Family	N/A
Thyroid Disease	☐	☐	☐	Diabetes	☐	☐	☐
Kidney Disease	☐	☐	☐	Macular Degeneration	☐	☐	☐
High Blood Pressure	☐	☐	☐	Glaucoma	☐	☐	☐
Arthritis	☐	☐	☐	Cataract	☐	☐	☐
Heart Disease	☐	☐	☐	Blindness	☐	☐	☐
Cancer	☐	☐	☐	Retinal Disease	☐	☐	☐

SOCIAL HISTORY (CONFIDENTIAL INFORMATION) *You may discuss this portion directly with your Doctor*

Do you use:

Alcohol ☐ No ☐ Yes: Type/Amount/How Long? ______________________________

Illegal Drugs ☐ No ☐ Yes: Type/Amount/How Long? ______________________________

Tobacco Products ☐ No ☐ Yes: Type/Amount/How Long? ______________________________

☐ I would prefer to discuss my Social History Information directly with my Doctor

AUTHORIZATION

I hereby give my consent to the doctors and staff of East Hill Optometry to provide eye care services to myself and/or family. I understand and agree (regardless of my insurance status) that I am responsible for the balance of the account.

ASSIGNMENT AND RELEASE

I, the undersigned certify that I have insurance coverage and assign directly to East Hill Optometry all insurance benefits, if any, otherwise payable to me for services rendered. **I 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 submission.

FINANCIAL DISCLAIMERS & LIABILITY

Insurance companies change their reimbursement and coverage often. I agree that as a service, East Hill Optometry contacts my insurance for an estimate of benefits and will file my claim. Estimates provided by my insurance are not a guarantee of payment. **It is my responsibility to know my own plan and available benefits**. In order for East Hill Optometry to bill my insurance, I will provide up to date insurance information by the day of my visit. I understand on the date of service, I am required to pay copays and charges above the estimate insurance payment; returned checks are subject to a $25 re-deposit and processing fee. Failure to show for an appointment and appointment cancellations/reschedules not made 48 hours prior may result in a $50 fee.

CONTACT LENS

I understand that if I choose to have contact lenses, East Hill Optometry charges $80 for a contact lens fitting fee, which may or may not be covered or discounted by my Insurance plan. This fee is due at the time of service. Fitting follow-ups made two months after the initial visit may be subject to additional charges. Only unopened boxes within 30 days of ordering can be returned, with a restocking fee of $15.00.

EYE GLASSES

If there are adjustments that need to be made to my glasses order, I must notify East Hill Optometry within 30 days of when the glasses are ready to be picked up. Any requested changes after that date may incur additional charges. Lenses are custom made for patients and therefore non-returnable.

HIPPA CONSENT

By signing this form, you consent to our use and disclosure of protected health information for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. East Hill Optometry may condition treatment upon the execution of this consent.

Additionally, by signing this form, you acknowledge that by presenting yourself as a patient or a child you consent for vision and medical care by Dr. Lum and the staff of East Hill Optometry. Your hereby grant full authority to Dr. Lum and respective assistants to administer and perform any and all drugs, treatments, test, or diagnostic procedures to or upon you, which may be advised, or necessary.

All health information may be shared with ________________________________ RELATIONSHIP _________________

PATIENT NAME ____

SIGNATURE ____ **DATE** __________________________________

RELATIONSHIP TO PATIENT (if other than patient) ____