PLAZA OPTICAL OF MONROE **PATIENT HISTORY INTAKE FORM**

FIRST NAME_____ LAST NAME_____ MI:_____

Address:_____ City:_____ State/Zip_____

Primary Phone:_____ Secondary Phone_____ Email:_____

Date of Birth:_____ Gender: M / F / Other_____Age:_____

Occupation:_____ Employer:_____

Referred by:_____ Date of Last Eye Exam:_____

Have you ever worn glasses? Y / N Do you wear glasses now? Y / N

Reason for today's visit (please check all that apply)

_____General Checkup _____Blurred Distance Vision _____Pain in Eyes

_____New Glasses _____Diabetic Eye Exam _____Itching in Eyes

_____Want Contact Lenses _____Update Contact Prescription _____Eyestrain

_____Headache _____ Lost/Broken Glasses _____Other:_____

Do you take any medications? Please list all medications and supplements_____

_____

(circle) diabetic meds, blood pressure meds, cholesterol meds, thyroid meds, antihistamines, birth control

Do you have any allergies? If yes, please list_____

Please mark if you or a family member have ever had any of the following conditions

Diabetes: Self or Family Member High Blood Pressure: Self or Family Member

Heart Disease: Self or Family Member Seasonal Allergies: Self or Family Member

Thyroid Problems: Self or Family Member Arthritis: Self or Family Member

HIV or AIDS: Self or Family Member Glaucoma: Self or Family Member

Cataracts: Self or Family Member Eye Surgery or Trauma: Y / N _____

Are you currently pregnant? Y/ N Are you currently breast-feeding Y / N

Have you ever worn contact lenses Y / N Do you wear contact lenses currently? Y /N

Brand of contact lenses worn_____ Powers/Prescription:_____

Patient Signature_____ Date:_____

Parent/Guardian Name (Please Print):_____Date:_____

Parent/Guardian Signature: _____Date:_____

**By signing I agree to be financially responsible for my or my child's fees

INSURANCE INFORMATION

Person Responsible for Account: (Last Name, First Name, MI)

_____

Relation to Patient_____Birthdate_____SSI# ***-**-_____(last 4 digits)

Address (if different from patient)_____

Phone#_____ Email_____

Person Responsible Employed by_____ Occupation_____

Name of Insurance _____

Contract #_____ Group#_____ Subscriber ID#_____

AUTHORIZATIONS

I CERTIFY THAT I HAVE INSURANCE COVERAGE WITH _____AND ASSIGN DIRECTLY TO PLAZA OPTICAL OF MONROE 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 AUTHORIZE THE USE OF MY SIGNATURE ON ALL INSURANCE SUBMISSIONS

PLAZA OPTICAL OF MONROE MAY USE MY HEALTH CARE INFORMATION AND MAY DISCLOSE SUCH INFORMATION TO THE ABOVE-NAMED INSURANCE COMPANY(IES) AND THEIR AGENTS FOR THE PURPOSE OF OBTAINING PAYMENTFOR SERVICES AND DETERMINING INSURANCE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES. THIS CONSENT WILL END WHEN MY TREATMENT PLAN IS COMPLETED OR ONE YEAR FROM THE DATE SIGNED BELOW.

Medicare/Medigap Authorization: I request that payment of authorized Medicare Benefits and if applicable Medigap benefits, be made with to me or on my behalf to Plaza Optical of Monroe for any services furnished to me by this provider.

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer and their agents any information needed to determine these benefits or benefits for related services.

_____ Date_____

Signature of Beneficiary, Guardian, or Personal Representative

_____ _____

Please Print Name of Beneficiary, Guardian or Personal Representative Relationship to Beneficiary