PATIENT INFORMATION

Last Name_____ Age_____ Today's Date_____
First Name_____
Middle Name_____
Street Address_____
City_____
State_____ Zip_____
Home Phone_____
Cell Phone_____
E-Mail Address_____

Sex of patient:___Male ____Female
Birthdate:_____
Social Security #:_____
Employer:_____
Work Phone:_____

Emergency Contact Name:_____
Emergency Contacts Phone :_____
Relationship to patient:_____

Employment Stauts:___Full Time ___Part Time ___Student ___ Unemployed ___ Retired

Insurance Information

Vision Insurance Name:_____
ID #_____
Plan/group# _____

Medical Insurance:_____
ID#_____
Plan/Group#_____

Release &Assignment: I authorize the release of any information necessary to process my insurance claims and assign and request payment directly to my physicians. I understand that insurance claims and assign and request payment directly to my physicians. I understand that eligibility and/or benefits cannot be guaranteed, therefore all outstanding balances left after insurance reimbursement are my responsibility including collection and attorney fees.

Signature:_____ **Date:**_____

Medical History

Date of last medical exam:_____
Primary Care Physician:_____
Phone# _____

Date of last eye exam:_____
Doctor or clinic name:_____
Phone#_____

Drug Allergies:____Yes ____No If yes, Please List:_____

Please check if any **Family Member** has had problems with: ___Glaucoma-whom_____
___Macular Degeneration-whom?_____

Please check if **YOU** have ever had problems with the following:

__Kidney Problems	__Diabetes	___Spots in Vision	___Cataracts	___Eye Injury
__ Asthma or Lung	__Thyroid	___Flashes of Light	___Burning Eyes	___ Eye Disease
__High Blood Pressure	__Hepatitis	___ Glaucoma	___Crossed Eyes	___ Eye Surgery
__Heart Problems	__HIV Postitive	___ Macular Degeneration	___Watery Eyes	___Headaches

Other:_____
Current Medications:_____

All eyeglasses and contact lens and prescriptions expire one year from exam date unless otherwise specified. Contact lens patients may be required to come in for follow up care before the prescription can be finalized.

Insurance Information

If insured is not the person being seen please fill out the following information:

Medical insurance name:_____
ID #_____
Plan/Group#_____

Last Name_____
First Name_____
Middle Name_____
Relationship to Patient_____
Address if Different from Patient_____
_____
Home Phone_____
Social Security#_____
Birthdate_____
Employer_____
Work Phone_____

Vision Insurance Name_____
ID #_____Plan/Group#_____

ACKNOWLEDGEMENT OF PRIVACY POLICY AND PRACTICES

100 Meridian Blvd ,Ste 106	3736 Annex Ave ,Ste 104	4811 Trousdale Dr Ste A
Franklin, Tn 37067	Nashville, Tn 37209	Nashville, TN 37211
615-771-6646	615-352-3330	615-823-2482

I understand that in an attempt to protect the privacy of my identifiable health information, Peace Eyecare has established a PRIVACY POLICY and guidelines for PRIVACY PRACTICES within our office. This information details the use and/or disclosure of information contained in my personal medical/optometric records be kept for the purpose of diagnosis, treatment, payment, and health care operations. In accordance with HIPPA regulations, a copy of the Peace Eyecare Privacy Policy and Practices has been made available to me while in the office today. Should I choose to have a personal copy one will be made available to me at no charge.

( ) I have read, understand and acknowledge the Privacy Policy and Practice of Peace Eyecare.
( ) I have elected not to read the Privacy Policy and Practices of Peace Eyecare.
( ) A copy of the Peace Eyecare Policy and Practices was given to me today.

_____

Print name of patient Date

_____

Signature of patient or guardian