First Name:_____ Last Name:_____ Nickname:_____

Home Address:_____City:_____ Zip:_____

DOB:___/___/_____ SSN:_____ Male Female

Phone: Home:_____ Work:_____ Cell:_____

Email:_____

What is your Reason for Today's Visit? _____

Taking Any Medications? Please supply a List to our staff or write them here:

_____

Please Circle Any Condition You Have Been Diagnosed With:

Constitutional: Developmental Disorder Cancer Fatigue Syndrome Other_____

Ear, Nose & Throat: Sinusitis Hearing Loss Laryngitis Dry Mouth Other_____

Neuro: Cerebral Palsy Tumor Multiple Sclerosis Epilepsy Stroke TIA Migraine Other_____

Psych: Bipolar Depression Anxiety Disorder Attention Deficit Other_____

Cardio: Hypertension Stroke Vascular Disease Heart Disease Heart Failure Other_____

Respiratory: Smoker Asthma Bronchitis Emphysema COPD Sleep Apnea Other_____

GI: Crohns Ulcer Colitis Celiac Disease Acid Reflux Other_____

GU: Chlamydia Kidney Disease STD Prostate Disease Pregnant Herpes Nursing Other_____

Musc/Skel: Gout Arthritis Osteoarthritis Fibromyalgia Muscular Dystrophy Osteoporosis Other_____

Integumentary: Eczema Rosacea Herpes Simplex/Cold Sores Psoriasis Shingles Other_____

Endocrine: Thyroid Dysfunction Hormonal Dysfunction Type 2 DM Type 1 DM Other_____

Hem/Lymph: Anemia Ulcer Blood Loss High Cholesterol Other_____

Allerg/Immune: Drug Allergies Sjogrens Lupus Rheumatoid Arthritis Environmental Allergies

Allergies:
Are You Allergic to Any Medications? Yes No

Please List:_____
Do You Have Any Environmental Allergies? Yes No

Please List:_____

Social History:
Do You Drink Alcohol: Yes No Drinks per week:_____

Do you Use Tobacco: Yes please circle (Cigarettes Cigars Pipe Smokeless) No

Smoking Status: Current Smoker Never Smoked Former Smoker Occasionally Former Smoker Daily

Insurance Coverage Information:

Medical Insurance:

Name Of Insurance Company: _____

Name of Primary Insured: _____

What is your relationship to primary insured? Self Spouse Parent

Primary Insured Date Of Birth: _____

Primary Insured SSN #: _____

Policy # _____

Group #_____

Vision Insurance:

Name of Insurance company: _____

Name of Primary Insured: _____

What is your relationship to primary insured? Self Spouse Parent

Primary Insured DOB: _____

Primary Insured SSN #: _____

Policy #: _____

Group # _____

Please make us aware of any insurance changes upon arrival. Insurance card should be present, we are unable to go back and bill insurance if it is not given on the day of your appointment. We understand some companies do not send out cards, however name of insurance should be known.

Thank you,

Dr Fries and Staff.

Insurance Signature On File

I certify that the information given by me in applying for insurance and or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and or Medicare benefits, and I authorize payment of these benefits to Fries Eyecare LLC dba Optique Family Vision Care on my behalf for any services and materials furnished. I authorize any holder of medical information about me to release to the Health Care financing Administration and its agents any information needed to determine these benefits payable to related services. If I have other health insurance coverage (as indicated in item 9 of the HCFA-1500 claim form or electronically submitted claim), my signature authorizes release of the above medical information to the insurer of agency shown, and authorizes my doctor to act as my agent as above. I assume financial responsibility for any copay's, deductibles not yet met and or in the case that my insurance company denies the claim.

_____ _____

Lifetime Patient Signature ***Date***

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I have been offered or received a copy of Fries Eyecare LLC's Notice of Privacy Practices. (located in waiting room)

Patient Name (printed): _____

Signature: _____ **Date:** _____