

Name: _____
 Address: _____

 Tel: (_____) _____ Type: Home / Mobile
 Email: _____
 Birthdate: ____/____/____ SSN: _____
 Sex: M / F Country of Origin: _____
 Primary Doctor and Phone:

 When was your last medical exam? _____

Are you experiencing any of the following?

<input type="checkbox"/> Red Eyes	<input type="checkbox"/> Floaters/spots
<input type="checkbox"/> Itching	<input type="checkbox"/> Flashes of light
<input type="checkbox"/> Burning	<input type="checkbox"/> Eye pain
<input type="checkbox"/> Tearing	<input type="checkbox"/> Light Sensitivity
<input type="checkbox"/> Sandiness	<input type="checkbox"/> Double Vision
<input type="checkbox"/> Dry Eyes	<input type="checkbox"/> Eye fatigue/strain

When was your last eye exam? _____

Do you have seasonal allergies? Yes / No

Have you ever been diagnosed with the following?

Cataracts..... <input type="checkbox"/> Yes	Glaucoma..... <input type="checkbox"/> Yes
Macular	Retinal
Degeneration..... <input type="checkbox"/> Yes	Detachment..... <input type="checkbox"/> Yes
Strabismus..... <input type="checkbox"/> Yes	Amblyopia..... <input type="checkbox"/> Yes
Diabetes..... <input type="checkbox"/> Yes	Stroke..... <input type="checkbox"/> Yes
Blood Pressure... <input type="checkbox"/> Yes	Heart Disease..... <input type="checkbox"/> Yes
Cholesterol..... <input type="checkbox"/> Yes	Thyroid..... <input type="checkbox"/> Yes
Asthma..... <input type="checkbox"/> Yes	Sinusitis..... <input type="checkbox"/> Yes
Rheumatoid	Osteoporosis..... <input type="checkbox"/> Yes
Arthritis..... <input type="checkbox"/> Yes	Cancer..... <input type="checkbox"/> Yes
Anemia..... <input type="checkbox"/> Yes	Kidney Disease... <input type="checkbox"/> Yes
Gastritis..... <input type="checkbox"/> Yes	Multiple Sclerosis <input type="checkbox"/> Yes
Depression..... <input type="checkbox"/> Yes	Rosacea..... <input type="checkbox"/> Yes
Migraines..... <input type="checkbox"/> Yes	HIV..... <input type="checkbox"/> Yes

Current Medications:

Allergies to Medications: _____

Preferred Pharmacy and Phone:

List prior surgeries(and dates) if any (e.g. LASIK)

Are you pregnant or nursing? Yes / No

Do you smoke? Yes / No Cigs per day: _____

Do you drink? Yes / No Drinks per day: _____

Do you have any family members that attend this office? Please list their name and relationship:

Do you have a family relative that has/had any of the following? Please indicate family members.

Glaucoma..... <input type="checkbox"/> Yes	Relation:_____
Macular	
Degeneration..... <input type="checkbox"/> Yes	Relation:_____
Diabetes..... <input type="checkbox"/> Yes	Relation:_____
Blood Pressure.. <input type="checkbox"/> Yes	Relation:_____
Cholesterol..... <input type="checkbox"/> Yes	Relation:_____
Stroke..... <input type="checkbox"/> Yes	Relation:_____
Heart Disease... <input type="checkbox"/> Yes	Relation:_____
Thyroid..... <input type="checkbox"/> Yes	Relation:_____
Cancer..... <input type="checkbox"/> Yes	Relation:_____

Visual Needs Assessment:

Occupation: _____

Do you wear contact lenses? Yes / No

Do you use sunglasses? Yes / No

Do you drive? Yes / No

Digital device usage per day : _____ hours

Sports/hobbies: _____

Notice of Privacy Practices Patient Acknowledgment

Date: _____

I understand that under the Health Insurance Portability & Accountability Act of 1996 (“HIPAA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand your *Notice of Privacy Practices* containing a complete description of the uses and disclosures of my health information. I understand that Ferrer Garcia Eyecare has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this office at any time to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____ Guardian Name (if applicable): _____

Signature: _____ Relationship to patient (if signed by guardian): _____

No Show/Cancellation Policy:

Ferrer Garcia Eyecare reserves the right to institute a formal policy regarding cancellations and “no shows”. A “no show” is defined as a scheduled appointment that the patient fails to keep. All appointments require a credit card number in order to secure your appointment. Patients are expected to confirm their appointments via call, text, or e-mail. If we do not receive a confirmation 48 hours prior to your scheduled appointment time, **your appointment will be canceled.** A fee of **\$45** applies to a confirmed appointment that the patient fails to keep. **I certify that I understand that I am responsible for any fees charged according to this policy and I grant the office permission to store my credit card information.**

Signature: _____

Payment Policy:

I hereby assign all medical benefits, including all major benefits to which I am entitled including Medicare, private insurance and any other health plans, to Ferrer Garcia Eyecare. I hereby authorize said assignee to release all information necessary to secure the payment. If my insurance company has not reimbursed Ferrer Garcia Eyecare within 60 days, I may be billed for any services or products that I have received. I understand that I am responsible for the balances due after billing. **I certify that I understand that there are no refunds or exchanges and that all sales are final unless covered under manufacturer warranty or office warranty programs.**

Signature: _____

With patient consent, the office is allowed to retrieve your prescription history, if available, to reconcile your medications. To opt out, please let one of our staff members know.