Patient Information

Patient Name___________________________________

Birth Date ____/____/____ SS#___________________

Address____

____

Home phone _______________________ ❒ Preferred #
Work Phone _______________________ ❒ Preferred #
Cell phone ________________________ ❒ Preferred #
Email ____
Communication Preference ❒ *Email* ❒ *Mail* ❒ *Phone*
Ok to leave detailed messages? ❒ Yes ❒ No
Employer_______________________________________
Occupation_____________________________________
Emergency Contact Name and Phone #

____
Marital Status __________________________________
Parent/Spouses Name____________________________
Parent/Spouses SS# _____________________________
Parent/Spouses Birth Date ________________________
Parent/Spouses Employer _________________________

How did you hear about us?

____

If patient or doctor referral, whom may we thank?

____

Please let us know whom we may speak with on your behalf

I give permission to Dr. Kim Crouch, OD & Optix Eye Care associates to speak to the following designated persons regarding my personal health information which includes diagnosis, care, prescriptions & billing:

Name: ____
Relation: ___________________ Ph #: ____________
Name: ____
Relation: ___________________ Ph #: ____________

Insurance Information

Vision Plan ____________________________________
Member ID#____________________________________
Subscriber Name________________________________
Relation to patient____________ Birth Date ________

Primary Health Ins ______________________________
Member ID#____________________________________
Subscriber Name________________________________
Relation to patient____________ Birth Date ________

Secondary Health Ins ____________________________
Member ID#____________________________________
Subscriber Name________________________________
Relation to patient____________ Birth Date ________

LIFETIME ASSIGMENT & RELEASE

I hereby assign directly to ***Kim Walters, OD, PA (business entity)*** 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 Dr. Kim Crouch to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. This signature and assignment is to be a continuing one, remaining in effect until revoked in writing by the undersigned.

Signature________________________ **Date**___________

To better serve your visual needs, please answer the following: <u>circle only answers that apply</u>

Do you wear any glasses? __________________________

____

Do you wear contacts? _____________________________

____

Do you wear sunglasses? ___________________________

Are they polarized? *Yes No I don't know*

Is safety protection a concern? *Yes No*

Do you perform fine or close-up work? *Yes No*

How much time do you spend on a computer (IPad, Smart phone, or Other LED Screen) each day?

None *1-2 hrs* *6-8 hrs*

Less than 1 Hr. *3-6 hrs* *more _____hrs*

Does computer use bother your eyes? _______________

Do you have any other visual requirements for your work or hobbies?

____

What hobbies or recreational activities do you enjoy?

____

____

Have you had Laser Vision Correction? *Yes No*

If not, are you interested in hearing more about laser vision correction? *Yes No*

Are you interested in learning more about *dry eye relief and/or reducing fine lines & wrinkles* on the face via TempSure radio frequency technology? *Yes No*

Please, CIRCLE only those that apply to your <u>current</u> eye health:

Blurred distance vision	Eye allergies
Blurred near vision	Itching eyes
Eye strain	Red/Bloodshot eyes
Poor vision	Burning eyes
Temporary loss of vision	Watering eyes
Eye injury	Dry eyes
Eye infection	Twitching eyelid
Discharge from eyes	Light sensitive
Poor color vision	Glare
Routine headaches	Poor night vision
Fainting spells	Macular Degeneration
Seeing flashes	Glaucoma
Seeing floaters or spots	Other Eye Disease:
Seeing halos	_______________
Double vision	

Date of last Eye Exam: ___/____/____

Doctor: ___________________________

OVER →