20/20 Optometric Eye Care
Patient Information

Today's Date: _____Referred By: _____

Patient Information:

First Name: _____ Last Name: _____

Address: _____ Apt #_____

City: _____ State _____ Zip Code: _____

Home Phone: (_____) _____ Cell Phone (_____) _____

____ check here if you would like to opt in for text message notifications

Date of Birth: _____/_____/_____ Age: _____ Sex: **M F**

Social Security Number: _____- _____ - _____

E-mail: _____@ _____

____ check here if you would like to opt in for email notifications

Driver's License Number: _____ Exp _____/_____/_____ Issue State _____

Married Legally Separated Single Widowed Minor Divorced Domestic Partner

Insurance Information:

Medical Insurance Plan: VSP Eye Med Spectera Davis MES Care Credit Flex Spending

Other: _____

Primary Insured's Name: _____

Primary Insured's DOB: _____/_____/_____

Primary Insured's Soc. Sec# _____-_____-_____

Primary Employed with (name of company):_____

Relation to Patient: _____

Group Number/ Member Number/ ID Number _____

Provider's Phone Number (_____) _____

Primary Care Physician: _____Phone Number _____

Medical Insurance Provider: _____

Group Number/ Member Number/ ID Number _____

Provider's Phone Number (_____) _____

Employment History of Patient:

Employed By:_____ Occupation: _____

Business Address:_____ Suite # _____

City: _____ State _____ Zip Code: _____

Business Phone: _____ Business Fax: _____

20/20 Optometric Eye Care
Health Questionnaire

Name: _____**Age:**_____

Emergency Contact:

Name of Person: _____ Relationship: _____

Address: _____ Apt # _____

City: _____ State _____ Zip Code:_____

Home Phone:_____ Alternate Phone: _____

Do you have?
(Place a check in the box near any health problems you may have)

_____**Diabetes**	_____ **High Blood Pressure**	_____ **Rheumatoid Arthritis**
_____**Asthma**	_____ **Sjogren's**	_____ **Colitis**
_____**Psoriasis**	_____ **Systemic Lupus**	_____ **Crohn's Disease**
_____**Depression**	_____ **Auto Immune Disease**	
_____ **Herpes**	_____**Thyroid Disease**	

Do you have any other medical conditions?_____

Are you Pregnant? **Y** **N** Nursing? **Y** **N**

Have you seen any **FLASHES** or **FLOATERS** in your vision? **Y N** Circle which one**: Flashes Floaters**

Have your pupils ever been dilated? **Yes** **No** When:_____

Have you had any eye surgery? **Yes** **No** When: _____

List any **medication/vitamins/eye** you are taking? _____

Are you **Allergic** to any medication? If so please list them: _____

Are you wearing contact lenses now? **Y N** If yes, what kind? **Hard** (RGP) or **Soft** ?

What is the **BRAND** name of the **SOFT** contact lens? _____

When did you last wear your contact lenses?_____

Do you sleep with your contact lenses on? **Y N**

What type of cleaning solution are you using? _____

How old is the prescription in your glasses? _____ Contacts? _____

I agree to pay in full for services rendered or materials purchased in case my insurance company denies coverage. I authorize the payment of medical benefits to the physician or supplier for the services rendered. I authorize the release of any medical or other information necessary to process the claim. I also request payment of government benefits to the party who accepts assignment.

Patient's Signature:_____ **Date:** _____

Parent's Signature *(If Under age 18) _____ **Date:** _____

HIPAA

Privacy Practices Acknowledgment & Authorization to Contact Patient/Record of Disclosures

I have read Twenty Twenty Optometric Eye Care's Notice of Privacy Practices, detailing how my information may be used and disclosed as permitted under federal and state law. I have been provided an opportunity to review the notice and I fully understand it. I request the following restriction(s) concerning the use of my personal medical information **(Please List ALL that applies):**

_____

_____

I understand that Twenty Twenty Optometric Eye Care is not required to agree to the restrictions requested. Further, I permit a copy of this authorization to be used in place of the original.

The HIPAA Privacy rule gives patients the right to request a restriction on uses and disclosures of their protected health information. The patient is also provided the right to request confidential communication or that a communication of the protected health information to be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner **(Check all that applies):**

- o Home Telephone Number: (_____) _____
- o OK to leave message with detailed information
- o Leave a message with call back number only
- o Cell Phone Number: (_____) _____
- o OK to leave message with detailed information
- o Leave a message with call back number only
- o Opt – In for Text messaging _____(int) msg and data rates may apply depending on your carrier

- o Work Telephone Number: (_____) _____
- o OK to leave message with detailed information
- o Leave a message with call back number only

Written Communication

- o E-mail address:_____

[You can elect

- o OK to mail to my home address
- o OK to mail to my work/office address
- o OK to fax to:_____

You and we agree to submit any dispute arising under this agreement, except a dispute alleging criminal violations, to arbitration in accordance with the Uniform Rules for Binding Arbitration of the Better Business Bureau of the Southland (published online at www.labb.org) in effect at the time of initiation of arbitration. A volunteer arbitrator will render a decision based on fairness, not necessarily upon legal principles, but it will be final and binding on both of us. Judgment on the decision may be entered in any court having jurisdiction. You will not have to pay anything for the arbitration.

This Agreement to Arbitrate affects important legal rights. Neither of us will be able to go to court for disputes once we agree in advance to arbitrate. And neither of us will be committed by the terms of this agreement to arbitrate unless this clause is initialed or unless your signature on this contract as a whole immediately follows this clause. Further information about BBB arbitration may be obtained by calling the Better Business Bureau in Colton at (909)825-0490. _____

(Initials of Customer)

Print Patient Name: _____ Date: _____

Patient Signature: _____ Date: _____

Parent Signature: _____ Date: _____

*(If under 18 years of age)