



WELCOME BACK FORM

Date: _____

Patient Information

Last Name: _____ First Name: _____ MI: _____
Preferred Name: _____ SS #: _____
Birth Date: _____ Age: _____ Gender: _____
Street: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____
Work Phone: _____ Email: _____
Occupation: _____ Employer: _____
Vision Insurance Plan: _____ Medical Insurance Plan: _____
Responsible for Account: _____

Medical & Ocular History

Reason for today's visit: new glasses contact lenses dry eyes diabetic exam LASIK
 failed vision screening other _____
Ocular health changes: no yes _____
Medical health changes: no yes _____
Current medications: no yes _____
Allergies to medications: no yes _____
Pregnant or nursing? no yes if yes, due date _____

Payment Verification / HIPAA

If you are using vision/medical insurance coverage for today's visit: I hereby authorize Associates In Eyecare, Optometrist, P. C., to retrieve or exchange any information necessary to process my insurance claim. I will receive services with the understanding in the event that any such coverage is denied, I will be held financially responsible. All deductibles, co-pays, non-covered services, and payment for materials are due on the date of service. Please acknowledge that you have read/agreed to this statement. I (name printed above) have been presented with the **Notice of Privacy Policy (HIPAA)** of Associates In Eyecare, Optometrist, P.C. and have been offered a copy of such policy for my records.

Visual Field & Digital Photography

Visual Field Test I accept I decline
Retina Photo I accept I decline

Patient Signature (parent/guardian if minor)	Doctor Signature	Date
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