PATIENT INFORMATION

Please check the information on this report for accuracy.
Please make corrections and fill in any missing information. Thank you in advance for your cooperation.

NAME:	
ADDRESS:	
CITY, STATE, ZIP:	
HOME PHONE:	**CELL PHONE:**
WORK PHONE:	
BIRTHDATE:	**MARITAL STATUS:**
SOCIAL SECURITY NUMBER:	
OCCUPATION/GRADE:	
EMPLOYER/SCHOOL:	
EMAIL ADDRESS:	

INSURANCE INFORMATION

(PRINT BELOW) INSURED NAME	**INSURED SOCIAL SECURITY**	**DATE OF BIRTH**

PRIMARY:	
SECONDARY:	
VISION:	

INSURANCE AUTHORIZATION

I request that payment of authorized insurance benefits for any services furnished me, be made on my behalf to:
CAROLINA OPTOMETRIC OF ARDEN OD, PA

I authorize any holder of medical information about me to release to my insurance company and its agents any information needed to determine these benefits payable for related services.

I understand that I am responsible for charges not paid by the insurance plan.

X_____ _____

Responsible Party (Relationship) **Date**

ACKNOWLEDGEMENT OF INSURANCE & PAYMENT POLICIES

We do not participate with all insurance companies. If you have insurance we do not participate with, payment will be expected when services are rendered. Carolina Optometric will file a courtesy claim for insurance companies we do participate with according to our contracts, however if the claim is denied or no payment is received from your insurance company within 30 days, the balance remaining will be transferred to you. *You, the patient, will be responsible for payment within 30 days to Carolina Optometric.*

I acknowledge that I have been advised of and understand this policy.

X_____ _____

Responsible Party (Relationship) **Date**

NAME: _____ DATE OF BIRTH:_____ AGE:_____

NAME OF PHYSICIAN:_____ PHYSICIAN PHONE:_____

MEDICAL HISTORY

PLEASE LIST ANY **MEDICATIONS** YOU CURRENTLY TAKE (or provide a list):

_____

ALLERGIES TO **MEDICATIONS /** REACTIONS:

_____

Do you have, or have you had any problems in the following areas? If "yes" provide further information.

	YES	NO	EXPLANATION OF PROBLEMS
RESPIRATORY (lungs, breathing)			
SKIN			
CARDIOVASCULAR (heart, blood pressure)			
HEMATOLOGIC/ LYMPHATIC (blood, lymph nodes)			
EAR/ NOSE/ THROAT/ DENTAL			
GASTROINTESTINAL (stomach, hepatitis)			
GENITOURINARY (genitals, kidney, bladder)			
MUSCULOSKELETAL (muscle, bone, joint pain)			
NEUROLOGICAL (brain, spine, nerves)			
MENTAL/EMOTIONAL CONDITION			
ENDOCRINE (diabetes, thyroid problems)			
CANCER			
GENERAL HEALTH			
EYES			
Burning, Gritty or Itchy			
Pain-shooting, Throbbing, Aching			
Flashing Lights/ Floating Spots			
Poor Night Vision			
Lazy Eyes or Crossed Eyes			
Eyes examined before? When? _____			Contacts? **Yes** or **No** **Contact Lens Brand:** _____ Glasses? **Yes** or **No**
Eye Disease			
Eye Injury/ Surgery			

PAST HISTORY, LAST 5-10 YEARS

List all MAJOR illnesses or injuries:_____

_____

List all MAJOR surgeries:_____

_____

FAMILY HISTORY	YES	NO	RELATIONSHIP TO PATIENT
BLINDNESS			
GLAUCOMA			
MACULAR DEGENERATION			
RETINAL DETACHMENT			
DIABETES			
THYROID			
HEART PROBLEMS			
HIGH BLOOD PRESSURE			
OTHER			

SOCIAL HISTORY

Current Occupation: _____

Any special vision needs? (computer etc.) _____

Hobbies: _____

Do you drive?	**YES**	**NO**
Do you drink alcohol?	**YES**	**NO**
Do you use tobacco products?	**YES**	**NO**
Have you ever been infected with a sexually transmitted disease?	**YES**	**NO**

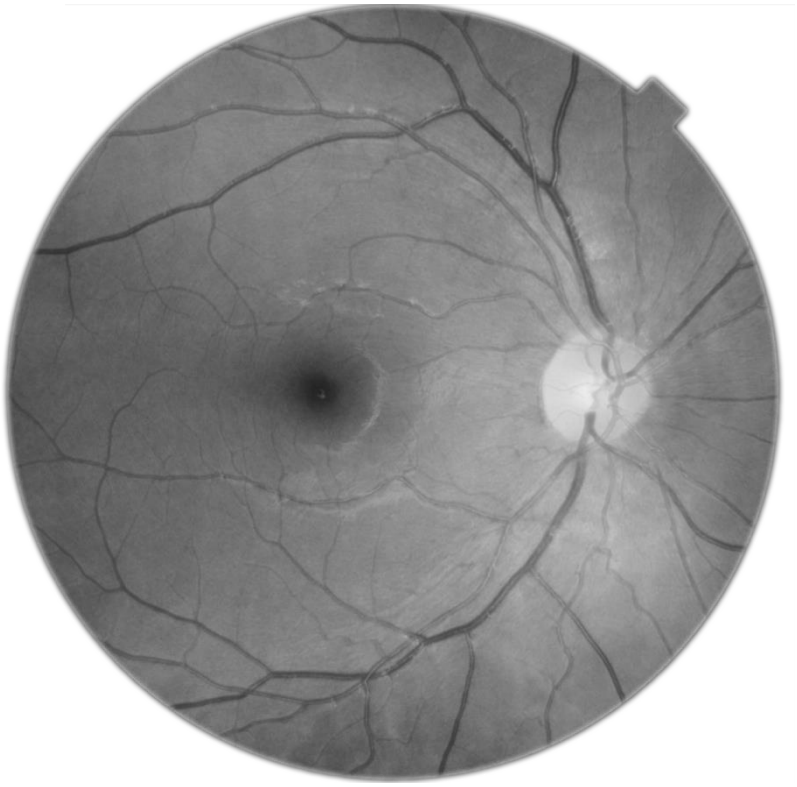
I have read and understand the **Notice of Privacy Practices** for Carolina Optometric of Arden, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

_____

Patients Signature Date

Who may we thank for referring you to our practice? _____

Have you ever seen the inside of your eye? We feel it is important for you to see what we see.



Many eye problems can develop without warning. To be sure your eyes stay healthy, we recommend having a retinal photo taken annually. The doctor can compare your photos year to year and look for changes over time.

This is especially important for patients that are diabetic or have glaucoma, macular degeneration, flashes, floaters, retinal disease or a strong eyeglass prescription.

The charge for this procedure is $28. If a medical condition is documented, we will bill your medical insurance company. If your insurance company allows this study, you will only be responsible for your specialist copay.

Would you like this procedure performed today? YES ____ NO ____

Signature Date