Welcome To Our Office

Please Print

Primary E-mail:_____

Date:_____ 2nd E-mail:_____

Name:_____ Sex: M ____ F ____ DOB: _____ Age: _____

Address:_____ First Visit? Yes _____ No _____

City/State/Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____Ok to text? **Y N**

Employed by: _____ Occupation: _____ SSN #_____

Primary Policyholder: _____ Policyholder DOB:_____ID#_____

Insurance Company: _____ Patient ID# _____

Secondary Insurance: _____ Patient ID# _____

Military? _____Family Member _____Active Duty _____Reserve _____Retired

Do you or have you worn Glasses? Y ____ N ____ What do you use them for? _____

When was your last eye examination? _____ Did anyone refer you? Who? _____

Your reason for visiting us today: (Please check any items)

___General Exam ___Eyes water ___Want contact lenses ___Bifocal Contacts
___Lost/Broken Glasses ___Glare problems ___Soft___Extended Wear ___Problems with current contacts
___Want new glasses ___Eyes Burn ___Gas permeable___Hard ___ Pain in the Eyes
___Blurred Distance Vision ___Dry Eye Eval ___See Spots or Flashes ___Blurred Near Vision

___Other (please specify):_____

___Headaches, when and how often? _____

Hobbies or specific vision requirements? _____

Your General and Ocular Health: Past or Present (Please check any items)

___ Hypertension ___Breathing problems ___Glaucoma ___Heart Disease ___Circulatory Problems
___Amblyopia ___Diabetes ___Multiple Sclerosis ___Retinal Disorders
___Allergie ___Drug Allergies ___ Eye Injuries ___Cancer ___Cataract ___ Eye Surgery (Any kind)
___Arthritis ___Strabismus ___ HIV Positive
___Other (Please specify)
_____ Are you pregnant? Y _____ N _____

Does anyone one in your family have any of the above-mentioned conditions. If so, what relative and condition?

_____

_____

If you take medicine for any reason, please list:_____

PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

Signature:_____ Date: _____

Insurance is a private matter between you and your insurance company. You are still responsible for all bills. Unpaid balances over 30 days from date of service will be subject to interest charges of 1.5% per month. Should collection/legal fees be necessary 50% of the unpaid balance will be charged as a collection fee.

WE WILL MAINTAIN A COPY OF YOUR RECORD FOR 5 YEARS AS APPLICABLE TO STATE LAW

Thank you for the privilege of allowing us to be of service to you.

GS/form WE-3 2015

Please Read and Sign

I hereby authorize Dr. Gene Sweetnam, O.D., P.C. dba Sight for Vision, Doctors of Optometry to release or exchange any information necessary to process my insurance claims. I will receive services with he understanding that in the event my coverage is not effective, I will be billed, by the provider, and held financially responsible for services rendered. Furthermore, I understand what my benefits are and that there may be additional charges over coverage benefits.

Patient, parent, or Legal Guardian's
Signature:_____

Date: _____