PATIENT INFORMATION (please print)

Patient's Name____
Last First Middle
Address ______________________City ____________State ______ Zip_______

Home Phone ____________ SS# ______________ Birth Date ________Age ______

Employed by ____________________Employer's phone__________ Work Related ? Y___ N____

Work Address __________________City_____________ State______ Zip _____

Sex: M F Marital Status: Single Married Divorced Widowed Separated (Circle One)

Name of Spouse or if a minor, Parent's name: ______________________________

How did you hear about us? Word of mouth Yellow Pages Dr____________________ (circle one)

Name of relative not living with you ________________________ Phone # __________

Address ______________________City__________ State________ Zip________

INSURANCE INFORMATION

PRIMARY INSURANCE:

Is this a Davis Vision Plan? Yes_____ No______ Eye Med Plan? Yes_____ No______

Main Person Insured: ___________________________ Insured's date of birth__________

Insurance Company______________________Employer of Insured _______________

Policy/Group ID # __________ Subscriber ID #______________SS # _______________

Relationship to patient: Self Spouse Son Daughter Mother Father Other__________

SECONDARY INSURANCE:

Is this a Davis Vision Plan? Yes____ No______ Eye Med Plan? Yes_____ No______

Person Insured: ___________________________ Insured's date of birth ___________

Insurance Company ____________________Employer of Insured __________________

Policy/Group ID #___________ Subscriber ID #______________SS #________________

Relationship to patient: Self Spouse Son Daughter Mother Father Other __________

FINANCIAL POLICY

I authorize the release of any information required in the course of my examination or treatment by the physician.
I authorize payment of medical benefits to the undersigned physician for services described.
I give the physician permission to treat this minor child in my absence.
Agreement for Extension of Credit:
In accordance with the Federal Truthin-Lending Act which requires all doctors to give their patients information in connection with extension of credit, please be advised of the following policies which apply in this office. The responsible party agrees to: **(Must be 18 years or older to provide signature.)**

1. **Pay the doctor at the time treatment or service is received or by previous arrangements.**
2. Pay for all legal fees and costs incurred in connection with debt collection with or without suit.
3. Pay the balance in full if my insurance company does not cover the entire balance of this account.
4. Pay a late fee of $5.00 per month after 90 days from the date of service.
5. Return checks will be subject to a $20.00 return check fee.
6. **Call 24 hours in advance to cancel or change an appointment to avoid a $100 fee.**
7. It is your responisibility to provide current and accurate insurance information. Failure to do so will cause your your visit to be self pay until insurance billing information is received.

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for services rendered. I have read all information on this form and consent to the terms outlined. I certify that all information provided on this form is true to the best of my knowledge. I understand these policies are subject to change without notice.

Responsible Party Signature ______________________________ Date: ______________

(Must be over 18 years of age) Relationship to patient: Father Mother Guardian Other ________________

ACKNOWLEDGMENT
(OF RECEIPT OF NOTICE OF PRIVACY PRACTICES)

I hereby acknowledge that a copy of Alta View Eye Care Clinic's Notice of Privacy Practices was provided to me. I further acknowledge and understand that if I have any questions about Alta View Eye Care Clinic's privacy practices or my rights with regard to my personal health information, I may contact the Office Manager for further information.

____
Please Print Name of Patient and Patients Representative, if one)

____
Signature of Patient (or Patient's Representative) **Date**

Relationship to Patient: Father Mother Guardian Self Other

____.

_____________ ____

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HEALTH INFORMATION AUTHORIZATION FORM

I hereby authorize the use or disclosure of my protected health information as described below and understand and acknowledge the following:

I am not required to sign this authorization and may in fact, refuse to sign this authorization. **Alta View Eye Care Center** will not condition my treatment or payment for my treatment on obtaining this authorization from me, unless permitted by law.
If the organization or person authorized to receive this information is not required to comply with the federal privacy regulations, the released information may be re-disclosed and would no longer be protected.
I may inspect or copy the protected information sought to be used or disclosed in this authorization, as permitted by the federal privacy regulations.
I have the right to revoke this authorization at any time. My revocation must be in writing and submitted to **Alta View Eye Care Center.** If I do revoke this authorization, however, my revocation will not affect any prior action taken in reliance on my authorization.
If I have any questions about this authorization, I may contact **Kathy Siskin at (801) 572-0631,** who will provide me with more information about this authorization, or about **Alta View Eye Care Center's** privacy practices.

Initials: _______

Please print full name of those persons or organizations authorized to receive, disclose of or use your protected health information identified above.

____

____

Please provide a specific description of your health information to be used or disclosed (identification, including dates). ____

____

____

____

D. This authorization will expire on (date)_______________; or upon the following event____

____

I certify that I have read, signed and received a copy of this authorization.

____
Signature of Patient (or Patient's Representative) Date

____
Relationship of Patient Representative to Patient Date

PATIENT HISTORY RECORD

DATE ______________ PRIMARY CARE PHYSICIAN ________________________________ PATIENT'S BIRTHDATE ______________

PATIENT NAME ____ SEX __________ AGE ______________

ADDRESS ________________________________ CITY ____________ STATE _________ ZIP ______________

OCCUPATION ________________________________ EMPLOYER ________________________________

HOME PHONE ____________________ CELL PHONE ____________________ WORK PHONE ____________________

Please answer the following questions about your medical status and history:

1. Have you ever been treated for a medical condition, such as diabetes, high blood pressure, arthritis, etc.? ☐ No ☐ Yes
Please explain: ____

2. Have you ever had any eye disease, such as glaucoma, cataract, lazy eye, etc.? ☐ No ☐ Yes Please explain: ________________

3. Have you had any surgery within the last 10 years? ☐ No ☐ Yes Please explain: ________________

4. Have you ever been hospitalized more than a day? ☐ No ☐ Yes Please list: ________________

5. Do you take any medication? ☐ No ☐ Yes Please list: ________________

6. Do you take any eye medication? ☐ No ☐ Yes Please list: ________________

7. Do you have any drug or food allergies? ☐ No ☐ Yes Please explain: ________________

Review of Systems

Do you currently have any of the following problems:

	No	Yes - Please explain:
Chronic fever, weight loss/gain, fatigue	☐	☐ ________________
Ear/nose/throat problems	☐	☐ ________________
Heart problems, chest pain, irregular heartbeat	☐	☐ ________________
Respiratory problems, wheezing, coughing	☐	☐ ________________
Gastrointestinal problems, heartburn, diarrhea	☐	☐ ________________
Urinary problems, discomfort, blood in urine	☐	☐ ________________
Skin problems, rash, excessive dryness	☐	☐ ________________
Joint muscle pain, aching or swelling	☐	☐ ________________
Neurological problems, numbness, weakness	☐	☐ ________________
Psychiatric problems, depression, anxiety	☐	☐ ________________

Family and Social History

Do any medical or eye diseases run in your family, such as diabetes, high blood pressure, glaucoma, etc.

____

Do you smoke? ☐ No ☐ Yes How Much? ________________

Do you drink alcohol? ☐ No ☐ Yes How Much? ________________

Comments ____

Doctor's signature ________________________ Date ________________

Date Reviewed for changes: ________________________________