

# Welcome to Our Office!

Please fill out the form below and bring it with you when you come in for your appointment.

Today's Date: \_\_\_\_\_



Patient's Name					
First		Last		MI	
Address					
City		State		Zip	
Home Phone	( ) -	Work Phone	( ) -	Cell Phone	( ) -
Social Security No.			Birth date		
Place of Employment			Occupation		
Name of Spouse			Email Address		
Name of Insured					
Date of Birth			Social Security No.		
Relationship to Patient					
Address					
City		State		Zip	
Telephone	( ) -	How did you hear about us?			

## INSURANCE

*\*Please give all insurance cards to the receptionist upon arrival\**

### PLEASE NOTE:

**IT IS THE PATIENT'S RESPONSIBILITY TO KNOW IF THEY ARE COVERED BY THEIR INSURANCE PLAN FOR "ROUTINE VISION." CONTACT LENS FITTINGS ARE USUALLY NOT COVERED BY INSURANCE. BE PREPARED TO PAY ANY ADDITIONAL COST FOR THE SERVICE. PATIENT IS RESPONSIBLE FOR ALL FEES REGARDLESS OF INSURANCE.**

Are you wearing contact lenses? (circle one)      YES / NO

Are you interested in wearing contact lenses?      YES / NO

Are you interested in LASIK procedure?      YES / NO

Reason for today's visit: \_\_\_\_\_

How were you referred to our office? \_\_\_\_\_

**I request that payment of authorized Medicare benefits or other insurance be made directly to Champion Eye Center and its affiliated doctors for any services furnished to me. I authorize any holder of medical of medical information about me be released to the health care financing administration and its agents any information to determine the benefits payable for related services.**

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

# Patient Health History



Patient's Name: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Primary Care Physicians _____	Date of Last Eye Exam _____
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## Have you ever been diagnosed with any of the following?

YES	NO		YES	NO		YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Musculoskeletal Problems	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Stroke/other Neurological Disease
<input type="checkbox"/>	<input type="checkbox"/>	Asthma or Breathing Problems	<input type="checkbox"/>	<input type="checkbox"/>	HIV Infection or AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Temporal Arteritis
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Trouble
<input type="checkbox"/>	<input type="checkbox"/>	Carotid Artery Disease	<input type="checkbox"/>	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Disorders	<input type="checkbox"/>	<input type="checkbox"/>	(Woman) Are you pregnant?
<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal Disease/Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Seizures, Convulsions, Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Do you smoke? ___ packs per day
<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Skin Disease	<input type="checkbox"/>	<input type="checkbox"/>	Do you consume alcohol? ___ drinks per day

If any of the above answers are YES, please explain:

List Your Current Medications:

List Any Medication Allergies:

## YOUR OCULAR HISTORY (Have you ever been diagnosed with any of the following?)

YES	NO		YES	NO		YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Floaters/Flashing Lights	<input type="checkbox"/>	<input type="checkbox"/>	Macular Degeneration
<input type="checkbox"/>	<input type="checkbox"/>	Cornea Disease	<input type="checkbox"/>	<input type="checkbox"/>	Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	Retinal Disease
<input type="checkbox"/>	<input type="checkbox"/>	Crossed Eyes/Lazy Eye (Amblyopia)	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Other Eye Disorders
<input type="checkbox"/>	<input type="checkbox"/>	Eye Infections	<input type="checkbox"/>	<input type="checkbox"/>	Iritis	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had eye surgery?
						<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had an eye injury?

If any of the above answers are YES, please explain:

## FAMILY HISTORY (Has anyone in your family (blood relative) had any of the following?)

YES	NO		YES	NO		YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Cornea Disease	<input type="checkbox"/>	<input type="checkbox"/>	Retinal Disease
<input type="checkbox"/>	<input type="checkbox"/>	Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>	Crossed Eyes/Lazy Eye	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure

If any of the above answers are YES, please explain:

## SURGERY HISTORY (Please indicate date and type of surgery)

Verified by (Tech Signature): \_\_\_\_\_ O.D. Signature: \_\_\_\_\_

Updated: \_\_\_\_/\_\_\_\_/\_\_\_\_

# Receipt of Notice of Privacy Practices & Consent Form



Champion Eye Center  
300 Julian Lane  
Arden, NC 28704  
(828) 650-2727

Champion Eye Center  
825B Merrimon Avenue  
Asheville, NC 28804  
(828) 236-0099

**Patient's Name:** \_\_\_\_\_

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services and to conduct health care operations involving our office.

The **Notice of Privacy Practices** you have been given describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this form. As described in our **Notice of Privacy Practices**, the use and disclosure of your health information for treatment purposes not only includes care and service provided here, but also disclosures of your health information for purposes of payment includes (1) our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; (2) our submission of your health information to auditors hired by third-party payers and insurers; and (4) other aspects of payment described in our **Notice of Privacy Practices**. Our **Notice of Privacy Practices** will be updated whenever our privacy practices change. You can get an updated copy here at the office (or from our website).

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services and to perform healthcare operations. You also signify that you have received a copy of our **Notice of Privacy Practices**.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or healthcare operations, but as described in our **Notice of Privacy Practices**, we are not obliged to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our **Notice of Privacy Practices** describes how to ask for a restriction.

**I have read this document and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations. I acknowledge that I have received the Notice of Privacy Practices from Champion Eye Center.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Source of Authority

## **Communication Release Authorization**

I, \_\_\_\_\_ give permission to Champion Eye Center to share my health information with the following people:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Contact Number: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Contact Number: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_