Medical Information Release Form

(HIPAA Release Form)

Name:_____ Date of Birth:_____/_____/_____

Release of Information

_____ I authorize the release the information including the diagnosis, records, examination rendered to me and claims information. This information may be released to:

_____ Spouse_____

_____ Child(ren)_____

_____ Other_____

_____ Information is not to be released to anyone.

*This **Release of Information** will remain in effect until terminated by me in writing.*

Messages

Preferred method of contact:

___ Home ___Work ___Cell #_____ ___Email _____
___Text my Cell

If unable to reach me:

_____You may leave a detailed message.
_____Please leave a message asking me to return your call.
_____Other:_____

The best time to reach me is (day)_____ at (time)_____.

Signed:_____ Date:_____/_____/_____

Witness:_____ Date:_____/_____/_____

WELCOME TO OUR OFFICE

Patient Name:_____ DOB:___/___/___ Age:_____ Gender:_____
Address:_____ City/State/Zip:_____
Home#:_____ Best #:_____ Driver's License #:_____
Email:_____ *Single___ *Married___ *Student___
Occupation:_____ Employer:_____

We will file most insurance claims that we are "Providers" for - when you complete the section below and provide the following: *Current insurance card/cards for us to copy, or bring a copy of front & back.
*A printed description of your vision and/or medical benefits.

Policyholder's Name:_____ Phone#:_____
Address:_____ City/State/Zip:_____
DOB:___/___/___ Social Sec #:_____ Relationship to Patient:_____
Employer:_____
VISION Plan:_____ **ID#:**_____ Group#:_____

If Policyholder is different for Medical Insurance (provide info on back)

Medical Insurance:_____ Your Physician:_____ Need Referral?____
ID#:_____ Group#:_____
*If Medicare, provide Secondary Insurance:_____
ID#:_____ Group#:_____

THE REASON FOR YOUR VISIT TODAY?:

___ Routine Eye Exam
___ Blurred Distance Vision
___ Blurred Near Vision
___ Headaches
___ Vision Improvements Options (Laser / Ortho-K)
___ Lost / Broken Glasses
___ Need Back-up / Computer Glasses
___ Want New Glasses
___ Want Contact Lenses
___ Worn Contacts Before
___ Medical Red Eye
___ Change Eye Color
___ RGP
___ Other

DO YOU OR IMMEDIATE FAMILY MEMBERS HAVE?:

Check for "You / Family"

__/__ Cancer / Tumor
__/__ Diabetes
__/__ Glaucoma
__/__ Heart Disease / Stroke
__/__ Hepatitis
__/__ High Blood Pressure
__/__ HIV / AIDS
__/__ Multiple Sclerosis
__/__ Pulmonary Disease
__/__ Retinal Disorder
__/__ STD's
__/__ Thyroid Problems

HAVE YOU EVER HAD?:

___ Eye Disease
___ Eye Injuries
___ Eye Pain
___ Eye Surgery
___ Amblyopia (Lazy Eye)
___ Strabismus (Eye Turn)
___ Flashes of Light
___ Floaters
___ Double Vision
___ Cataracts
___ Retinal Disorders

Other Comments / Problems:_____
*Do you smoke? ___Never ___Occasional ___Often *Drink alcohol? ___Never ___Occasional ___Often
Are you pregnant or nursing? ___Yes
List any medications you are taking:_____
List any medications you are allergic to:_____

Sign:_____ Date:_____