Patient Name: _____

Date of birth: _____ Age: _____ Sex: _____

Do you have any of the following medical conditions?
(circle yes or no)

DIABETES	YES	NO
HIV	YES	NO
RHEUMATOID ARTHRITIS	YES	NO
HEPATITIS C	YES	NO
LUPUS	YES	NO
NURSING	YES	NO
PREGNANT	YES	NO

List all medications you are currently taking.
(birth control, hormones, vitamins, allergy or any over-the-counter, etc.)

_____

_____

_____

_____

_____

List all past and current Medical Conditions.
(high blood pressure, allergies, thyroid, etc.)

_____

_____

_____

_____

_____

Are you ALLERGIC to any medications or LATEX?
(circle yes or no) YES NO

_____

_____

_____

Do you wear Contacts Lenses?
(circle yes or no) YES NO

Do you sleep in your contacts?
(circle yes or no) YES NO

When did you last take them out?

_____

_____

What type of contacts do you wear?
(circle yes or no)

SOFT	YES	NO
HARD	YES	NO
DAILY LENS	YES	NO
BI-WEEKLY LENS	YES	NO
MONTHLY LENS	YES	NO
DISPOSABLE LENS	YES	NO

Have you had any type of Eye Surgery?
(circle yes or no) YES NO
(if yes, please describe and include date)

_____

_____

Do you have a history of any Eye Disease?
(circle yes or no) YES NO
(if yes, please describe)

_____

_____

Do you have a family member with any Eye Disease?
(circle yes or no) YES NO
(if yes, please describe)

_____

_____

Carolinas Eye Center has provided me with the Notice of Privacy Practices (HIPPA law).

Patient Signature _____ Date _____

Parent or Guardian Signature _____ Date _____

PATIENT INFORMATION

PLEASE PRINT

LAST NAME	FIRST NAME	M.I.	BIRTHDATE
ADDRESS	CITY	STATE	ZIP
HOME PHONE	CELL PHONE	WORK PHONE	AGE
SOCIAL SECURITY #	EMAIL ADDRESS		
EMPLOYER	EMPLOYER ADDRESS		SEX
EMERGENCY CONTACT NAME	EMERGENY #	RELATIONSHIP	

SPOUSE/ NEAREST RELATIVE INFORMATION

SPOUSE/ NEAREST RELATIVE NAME	RELATIONSHIP	BIRTHDATE	
ADDRESS (IF DIFFERENT FROM ABOVE)	CITY	STATE	ZIP
HOME PHONE	CELL PHONE	WORK PHONE	

PRIMARY INSURANCE INFORMATION

INSURANCE CARRIER	INSURANCE ADDRESS		
INSURANCE PHONE NUMBER	POLICY ID	GROUP #	
POLICY HOLDER NAME	BIRTHDATE	RELATIONSHIP	
SOCIAL SECURITY #	PHONE NUMBER		
ADDRESS (IF DIFFERENT FROM ABOVE)	CITY	STATE	ZIP
EMPLOYER	EMPLOYER ADDRESS		
EMPLOYER PHONE NUMBER			

SECONDARY INSURANCE INFORMATION

INSURANCE CARRIER	INSURANCE ADDRESS		
INSURANCE PHONE NUMBER	POLICY ID	GROUP #	
POLICY HOLDER NAME	BIRTHDATE	RELATIONSHIP	
SOCIAL SECURITY #	PHONE NUMBER		
ADDRESS (IF DIFFERENT FROM ABOVE)	CITY	STATE	ZIP
EMPLOYER	EMPLOYER ADDRESS		
EMPLOYER PHONE NUMBER			

FINANCIAL POLICY/AUTHORIZATION TO RELEASE INFORMATION TO PAY

I understand that I am responsible for all medical expenses, regardless of insurance coverage and whether or not there is an accident with another person at fault. I hereby authorize CAROLINAS EYE CENTER to release any information acquired in my treatment to insurance company(ies) listed above. I hereby authorize payment directly to CAROLINAS EYE CENTER for my treatments(s). In order to obtain proper authorizations, by signing below I verify I have presented the most current insurance cards.

SIGNATURE OF PATIENT **IF MINOR, GUARDIAN SIGNATURE**

RESPONSIBLE PARTY INFORMATION (if Different than above) **DATE**

CAROLINAS EYE CENTER

SUMMARY NOTICE OF PRIVACY PRACTICES & ACKNOWLEDGEMENT OF RECEIPT: Under federal law, Carolinas Eye Center is required to protect the privacy of certain parts of your protected health information (PHI) we hold in our files. Upon your request, Carolinas Eye Center must give you a notice (referred to as our "Notice to Privacy Practices") of our legal duties and privacy practices concerning the permitted uses and disclosures of your PHI and your rights regarding our use and disclosure of your PHI. You have the legal right to review our Notice of Privacy Practices before you sign this consent. You have the right to request us to restrict how we use and disclose your PHI for the purposes of treatment, payment, or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement with you. You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your PHI on reliance of your consent. By signing this form, you are granting consent to Carolinas Eye Center to use and disclose your PHI for the purposes of treatment, payment, and health care operations.

I hereby acknowledge that I have been provided this Summary Notice of Privacy Practices and understand that I may at any time request to receive the full Notice of Privacy Practices from Carolinas Eye Center.

ACCEPT _____ DECLINE_____

FINACIAL POLICY: Our financial policy is an essential element of your care and treatment. To give you the best care and service possible please read the following financial policy. Should you have any questions, feel free to discuss them with a member of our staff. Unless prior arrangements have been made, by either yourself or your insurance carrier, full payment is due at time of service. The accompanying adult to a minor patient is responsible for payment. For your convenience, we accept Visa and Master Card. If you have Medicare coverage, you will not be billed for services until after Medicare has processed your claim. You will receive a statement from our service after we receive payment from Medicare. We will bill those plans with which we have a prior agreement with and will collect required co-payments at the time of service. If your health plan determines a service to be "not covered", you will be responsible for the complete charge or remaining balance. Payment is due upon receipt of that statement. Charges for your care and treatment(s) will be due at that time of service. Co-payments are due at the time of service. Authorization from insurance companies may be required for office visits in order to receive full benefit coverage. If you are not sure authorization is required for your plan, please contact your insurance company, employer or primary care physician. If required, an authorization must be received by our office prior to your visit. Failure to provide Carolinas Eye Center with proper authorization may result in delay or rescheduling your appointment. You will also be responsible for all services related to your visit. I have read and understand the financial policy set forth by Carolinas Eye Center, and I agree to be bound by its terms. I also understand and agree that such terms may be amended periodically by the practice.

ACCEPT _____ DECLINE_____

Signature of Patient or Responsible Party: _____Date:_____

Name of Patient (please print) _____