Affinity Eye Care **Patient Registration and Medical History Form**

Please Print Clearly

Today's Date: ___/___/___

Name____ Date of Birth: ________________ Age: ______

Current Address____ Marital Status: _______

City, State, Zip Code: ____

Email address: ____ Have you been to our office before? Yes / No

Phone Number: ______________________________ Occupation: _________________________________

How did you hear about our practice? ____

Vision Insurance: _______________________________________ **(We will need to make a copy of your card)**

Eye and Vision History

Do you wear GLASSES? YES / NO If yes, Do you wear them for: Driving /Reading/ Both

Do you currently wear CONTACT LENSES? YES / NO If yes, Do you wear them overnight? YES / NO
If NO, do you have a interest in starting or restarting contact lens wear? YES / NO

Do you have a history of eye surgeries or serious injury or infection in the eye? YES / NO
If YES, please explain: ____

Are you interested in learning more about Lasik? YES / NO

Please read and sign below carefully. For your convenience, we will bill your primary insurance company. It is your responsibility to know your insurance benefits. Once the insurance has been billed, changes to that billing CANNOT be made, and any amounts due will be your responsibility. I understand that my personal information will never be shared with any other person, provider, or insurance company without my consent. I authorize Affinity Eye Care, LLC to send my bills for medical care treatment to my insurance company, other payer for payment. I request my insurance company to pay Affinity Eye Care, LLC. For the treatment provided. I agree to pay for any charges not covered by my insurance. Affinity Eye Care, LLC. Will be billing your insurance company between $123.00-$214.00 depending on the outcome of your exam. Affinity Eye Care, LLC. Does offer a same day payment of **84.00** if you are unsure or have no vision insurance. I agree that my insurance can be billed. I consent to and authorize Affinity Eye Care, LLC. to access and treat me.

Signature____Date___________________________

Privacy Policy:

All Doctor's offices must keep your information confidential due to laws known as HIPAA. We have given you our policies in regards to how we process your information on a separate sheet attached to this clipboard. Please sign below stating that you have read our statement or simply write "I decline to sign" (Your signature simply represents we attempted to share with you our HIPAA policies.)

Signature____ **Date:** ___________________________________