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 an 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: _____

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 payers 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 **99.00** 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:** _____