PATIENT INFORMATION FORM

Name: ____________________________________ Home Phone: (____)______-_________
Address: __________________________________ Cell Phone: (____)______-_________
City, State: ________________________________ Emergency Phone: (____)______-______
Zip: _______________ Email: _____________________________
Sex: M or F Date of Birth: ____/_____/_______ Age: _______
Social Security #: ______-______-_______ Height: __________ Weight: _________
Employer/School: _______________________ Occupation/Grade: ___________________
Married: Y or N

Is there anyone, besides yourself, that we may discuss your medical information with? If so, please list:
____
Have we seen other family members?____
Whom may we thank for referring you? ____
How would you prefer to receive future correspondence: Text Email Phone

INSURANCE

Insurance Company: __________________ Policy # ________________ Group #______________
Name of Insured: ___________________________ Relationship to Patient: _________________
SS # of Insured: _____-______-________ DOB of Insured: _____/______/__________

Assignment of Release of Insurance:

I certify that I, and/or my dependent(s) have coverage with the above insurance and assign directly to Dr. Ashley E Bradford all insurance benefits, if any, otherwise payable to me for services rendered, I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named insurance company(s) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable to related services. Claims will be filed by HCFA or electronically.

Print Name: _________________________

Signature: __________________________

Date: ____________________ Relationship to Patient: _______________________

MEDICAL HISTORY

Last Eye Exam: ____________________ Name of Doctor: ___________________________

Do you wear glasses? Yes or No Do you wear contacts? Yes or No

Primary Care Doctor: _______________________ Date of last visit: ___________________________

Pharmacy: _________________________________

Are you pregnant? ______ Nursing? _______ Alcohol Use? _______ Tobacco Use? ______

Please check any condition that applied to yourself or any members of the immediate family.

	Self	Family		Self	Family
Diabetes			Flashes/Floaters		
High Blood Pressure			Itching Eyes		
Heart Problems			Glaucoma		
Breathing Problems			Cataracts		
Thyroid Problems			Macular Degeneration		
Headaches			Retinal Detachment		
Cancer			Eye Surgery		
Hepatitis (type___)			Lazy Eye		
AIDS/HIV			Crossed Eyes		
Arthritis			Blindness		
Blurred Vision			Red Eyes		
Eye Strain			Eye Infection		
Double Vision			Dry Eyes		
Head/Eye Injury			Light Sensitivity		
Watery Eyes			Temporary Vision Loss		
High Cholesterol			Depression/Anxiety		

Other ailments or diagnosis not listed above:

____

____

Do you have any drug/seasonal allergies? If so, please list:

____

List any current medications you are currently taking, including eye drops:

____

____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

The full notice of privacy practices of Haughton Vision, LLC is available by request from our check in desk and is also available online at www.haughtonvision.com . I have read (or had the opportunity to read if I so chose) and understand the notice.

Print Patient Name: ________________________________ Date: ________________________

Patient or Authorized Representative (if applicable): _______________________________________

Signature: ____