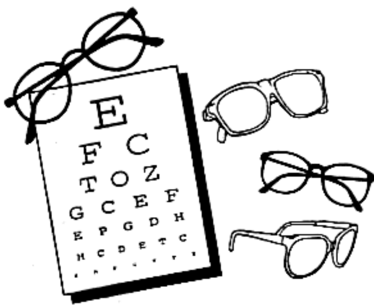

PATIENT INFORMATION

Today's Date ______________________

PATIENT INFORMATION

Name: Last ______________________ First: ______________________ Middle: __________

Address ______________________ City ______________________ State/ZIP __________

Phone: Home ______________________ Cell ______________________ Work. ______________________

E-mail Address ______________________

Birthdate ______________________ Social Security # ______________________

Sex *(Please Circle)* M F   Marital Status: Single Married Widow Divorced Separated

Race/Ethnicity __American Indian or Alaska native __Asian __Black or African American __Spanish/Hispanic/Latino __White or Caucasian

Occupation ______________________ Employer ______________________

If a student, School Name ______________________ School Address ______________________

Grade __________ Mother's Name ______________________ Father's Name ______________________

RESPONSIBLE PARTY INFORMATION (COMPLETE IF DIFFERENT THAN PATIENT)

Responsible Party's Full Name ______________________ Relationship to Patient ______________________

Address ______________________ City ______________________ State/ZIP __________

Phone: Home ______________________ Work ______________________ Ext. __________

INSURANCE INFORMATION

Primary Insurance ______________________ Group # ______________________

Address ______________________ ID# ______________________

Subscriber ______________________ Subscriber's Birthday ______________________

Employer ______________________

EYE HISTORY

Date of last exam ______________________

Do you currently wear glasses? YES / NO

Do you currently wear contact lenses? YES / NO

Did you ever have eye surgery, eye disease or any eye injury? YES / NO

If yes, please explain ______________________

Does anyone from your blood-related family have any history of eye disease or eye surgery? YES / NO

If yes, please explain ______________________

HEALTH HISTORY

What is your general health? ______________________________

Do you have problems with any of these systems? *(please circle all that apply)*

Gastrointestinal	YES / NO	Nervous	YES / NO	Mental	YES / NO
Ears/Nose/Throat	YES / NO	Genitourinary	YES / NO	Endocrine (glands)	YES / NO
Cardiovascular	YES / NO	Musculoskeletal	YES / NO	Blood/lymph	YES / NO
Respiratory	YES / NO	Integumentary (skin)	YES / NO	Allergic/immunologic	YES / NO

Please explain ______________________________

Please answer all that apply:

Diabetes YES / NO Type ______________ Date of Diagnosis ______________

Allergies YES / NO Allergic to what? ______________ What happens? ______________

Medication allergy YES / NO What happens? ______________ Headaches YES / NO

Current medication(s) ______________________________

____

Name of primary doctor ______________ Date of last visit to primary doctor ______________

Doctor's address ______________ Phone # ______/______/______

FAMILY HISTORY

High blood pressure YES / NO Relationship ______________

Diabetes? YES / NO Relationship? ______________

Thyroid condition? YES / NO Relationship? ______________

FINANCIAL ASSIGNMENT & AGREEMENT

1) I authorize Dr. Niemczyk & Associates to file insurance claims on my behalf and accept benefits when appropriate. I also authorize release of any information to determine these benefits by the insurance company.

2) It is my responsibility to pay any balance not paid by my insurance, such as non-covered routine eye exam, deductible, co-insurance or refraction (the part of the exam that determines eyeglass prescription).

3) Should I be a Medicare beneficiary, I understand that the refraction (the part of the eye exam that determines eyeglass prescription) is a non-covered service.

4) If my insurance requires a referral to allocate payment to Dr. Niemczyk & Associates and I do not have a referral at the time of services, or I do not present an appropriately dated referral within one week from time of services, I will accept financial responsibility.

5) Should I present Dr.Niemczyk & Associates with incorrect insurance information at the time of services, I understand that Dr.Niemzcyk & Associates will not be responsible for submitting additional claims and that I will accept financial responsibility.

6) Any optical appliance prescribed by Dr. Niemczyk & Associates will require payment in full or a 50% deposit at the time of ordering. Any remaining balance must be satisfied before the optical appliance will be dispensed.

7) I agree that if my account is referred to an outside agency or attorney for collection, I will be responsible for an additional Collection Fee of fifty dollars ($50.00) or 20% of the balance owed, whichever amount is greater.

PRINT NAME______________________________

SIGNATURE______________________________ DATE______________