PATIENT INFORMATION

Date:____________

First Name:___________________ Middle Initial____ Last Name________________________

Age________Date of Birth _______________ Social Security # ________________________

Street Address(Required) ____

P.O. Box # ___________ City________________________ State_______ Zip______________

Home Phone________________Work Phone________________ Cell Phone_______________

Employer____Occupation___________________

Whom may we thank for referring you:____

Insurance_________________________________Gr#_____________ID#_________________

Member Name____________________________Address______________________________

Member Date of Birth_____________ Relationship to patient___________________________

Secondary Insurance?____

____

Date of last Exam________________Is this exam for glasses? _________Contacts?_________

Do your vision problems occur at Distance_______Near______

Do you have headaches? Yes_____No____ Sensitive to light? Yes_____ No______

Do your eyes Burn____Ache____Tire____Itch_____Water_____Get Red___Feel Dry___

Hobbies____

Do you work with a computer? Yes____No_____ How many hours per day?______________

Have you ever had any of the following ? (Check all that apply)

Problems with Glare_____Diabetes_____Heart Problems____High Blood Pressure________

Glaucoma_____Eye Injury____Eye Surgery____Retinal Detachment_____

Has any family member ever had any of the following? (Family members include grandparents, parents, brothers and sisters)

Glaucoma__Diabetes__Macular Degeneration__ Blindness__Cataracts__Retinal Detachment__

List all medications you are taking (including birth control and hormones)___________________

____

List all medications you are allergic to:____

Family Physician:___________________________Dentist______________________________

Payment method: Cash___ Check___ Credit Card___ Insurance___

DILATION: I understand that all professional fees are to be paid at the time of examination.
If dilation is required, there will be an additional charge of $15.00 payable the
day of dilation.

INSURANCE FILING: I understand that I will be responsible for payment in full for any
services or material rendered to me by Handley Optical or
Dr. Bobby Larson. I may submit insurance information; however,
if the insurance carrier(s) does not pay the entire balance, or denies or
rejects my claim for any reason, I understand I will be responsible
For paying my account balance in full.

Signature____Relation to Patient______________
Date______________

I hereby authorize release of any information concerning my (or my childs) examination and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also authorize payment directly to the doctor for any insurance benefits otherwise payable to me.

Signature____Date_____________________

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form please ask to speak with our HIPPA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only an acknowledgment that you have received or read our Notice of Privacy Practices.

Signature _________________________Print Name_______________________Date_________