



Patient Information

Date _____

Please Print Clearly

Last Name First Name MI / / Age Male / Female

Current Street Address City State Zip Code

Home Telephone () _____ Cell () _____

Work Telephone () _____

Would you prefer to be texted to confirm your appointment? Yes _____ No _____

Employer _____ Occupation _____

Employers Address _____

Emergency Contact _____ Telephone # _____ Relationship _____

Email _____ May we email you? Yes _____ No _____

HOW DID YOU HEAR ABOUT US / WHO REFERRED YOU?

Your Optometrist:
Name: _____
Phone #: _____
Address: _____
City: _____ State: _____ Zip Code: _____

Your Primary Care Physician:
Name: _____
Phone #: _____
Address: _____
City: _____ State: _____ Zip Code: _____

Friend / Relative: Name: _____ Direct Mailing _____

Insurance: Company: _____ Other: Explain: _____

Ocular History

What medications are you currently taking? _____

Are you currently taking any eye medications? _____

Carefully tell us about your medication allergies: _____

How often does your glasses prescription change? _____

Do you have a history of any eye problems or surgeries? _____

Insurance Information:

Primary Medical Insurance _____ Secondary Medical Insurance _____

Vision Insurance _____

Insured Name _____ Date of Birth ____ / ____ / ____

Social Security Number (SSN) _____

Single _____ Married _____ Widowed _____ Divorced _____ Other _____

Reason for Exam: _____

I authorize the release of information from my records at McNelis Family Eyecare in order to process claims to my medical insurance. I also authorize any insurance payments made to be assigned to McNelis Family Eyecare.

I understand that I am responsible for all charges not covered by my insurance plan including my co-pay and yearly deductible. I also understand it is my responsibility to inform McNelis Family Eyecare of any Vision or medical plans I am affiliated with but it is my responsibility to find out what the coverage and/or benefits are. All vision plans must be discussed at time of visit.

Acknowledgement of receipt of Notices of Privacy Practices:

I acknowledge having the opportunity to read and /or receive a copy of McNelis Family Eyecare Notice of Privacy Practices.

Signature _____ Date ____ / ____ / ____ Relationship to patient _____

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*****Find us on Facebook: Margaret McNelis *****