RETURNING PATIENT INFORMATION UPDATE

Thank you for returning to Active Eyecare of Surprise! Please take a few moments to update us on any changes in information about yourself, your health, and your visual needs so we can better serve you.

Last Name: _____**First**_____**MI**____ **Today's Date:** _____

Address: _____**Gender (M) (F)** **Occupation:** _____

City: _____ **State:** _____ **Zip:** _____ **Home Phone:** _____

Date of Birth: ____/____/____ **SSN** _ _____-_____-_____ **Cell Phone:** _____

Parent/Guardian (if applicable): _____ **E-mail:** _____

Primary Care physician: _____ **Last Eye Exam:** _____

HIPAA Notice and Acknowledgement

I acknowledge that I have been provided the HIPAA Notice of Privacy Practices ___Yes ____No

Patient Insurance Information Update

Primary's Name: _____ Primary's DOB: _____/_____/_____
Name of Plan or Insurance: _____ Primary's Employer: _____
Primary's ID or SSN: _____ Group Number: _____

Changes in Ocular/Medical/Family History

Chief Complaint: What is your primary reason for this visit?_____
Are you experiencing any new ocular or visual problems?_____
Have you been diagnosed with any new ocular conditions or diseases since your last visit?_____
If you wear glasses, are you having any problems with them? _____
If you wear contacts, are you having any problems with them?_____
Are you currently using any ocular medicines or eye drops?_____
Have you had any changes in your health since your last visit?_____
Are you taking any new Rx or over-the-counter medicines?_____
Have there been any changes in your family medical/ocular history?_____
Are there any other questions or concerns you would like addressed today?_____

ATTENTION CONTACT LENS PATIENTS

A contact lens fitting is a professional service separate from the routine vision exam. The fitting includes the trial lenses and any follow-up appointments to provide you with a contact lens prescription. By signing below, you acknowledge that you can use your insurance benefits to cover the contact lens fitting, **OR** you will pay for the contact lens fitting at the time of service.

Signature (patient/responsible party)_____Date_____

Would you be willing to provide feedback to us on your experience today via a text message or e-mail survey? ____Yes ____No

ACKNOWLEDGEMENTS AND SIGNATURE

I acknowledge that the health and insurance information I have provided above is true and correct to the best of my ability. I authorize payment of any vision or medical benefits I may be eligible for directly to Active Eyecare of Surprise. **I agree that if my employer, insurance carrier, or plan sponsor denies payment to all or any part of my claim, I will be financially responsible for all outstanding charges.** I acknowledge that authorization obtained at the time of service does not guarantee payment, and any services not covered by insurance will be billed to me. In the event it becomes necessary to place any unpaid balances I am responsible for in collection, I agree to pay any collection fees, reasonable attorney fees, filing fees, and other costs the court determines are proper. I have read the conditions of service, and as the Patient or the Patient's Authorized Representative I hereby accept these terms.

Signature of Patient or Responsible Party _____ **Date:** _____