Insurance Notice

As a courtesy to you, this office will file your insurance plan.
Please be aware that any benefits given are NOT a guarantee of payment to this office. Depending on your plan and what they pay or do not pay to this office can affect your account. In some instances, you could receive a bill or a credit.

If you are asked to pay up front and out of pocket, please know that we charge you a discounted rate and we charge the insurance plan our usually and customary fee. If you have any questions concerning your account or insurance plan, please ask the doctor or the office staff.

________________________________ ________________________________
Signature(guardian if pt is a minor) date

Acknowledgement of Privacy Practice

I acknowledge that I have read a copy of Dr. Gerald Graefe's Notice of Privacy Practices.

Patient Name____________________________

Signature ________________________________ Date____________________

Today's Date______________

WELCOME TO OUR OFFICE

PATIENT INFORMATION

Thank you for choosing our practice for your eye care needs. Please complete this form.

Name ____ SS # ______________________________

Address _______________________________________ City ______________________ State___________

Zip __________ Home phone No. _____________________ Work phone No. ______________________

Birth date_______________ Age________________ E-mail _______________________________________

Do you prefer to receive calls at: ☐ Home ☐ Work ☐ Either
Are you: ☐ Minor ☐ Married ☐ Divorced ☐ Widowed ☐ Single

Your Employer ______________________________ Occupation ___________________________________

Spouse's / parent's name ________________________________ Workplace _________________________

Spouse's / parent's Work phone # _________________________

Whom may we thank for referring you to us? ______________________________

RESPONSIBLE PARTY

Name of person responsible for this account _________________________________

Relationship to patient __________________ Phone # _________________________

INSURANCE INFORMATION

Name of insured__________________________ Relationship to patient_____________________________

SS# _________________Date of Birth_______________ Name of insurance co.______________________

HEALTH HISTORY

Reason for today's exam

____

Date of last exam _______________________Name of eye doctor __________________________________

Over >

Do you or anyone in your family have a history of the following?
☐ Diabetes ☐ Blindness ☐ Cataracts ☐ High blood pressure
☐ Thyroid ☐ Turned or lazy eye ☐ Glaucoma ☐ Heart condition

Please check any of the following conditions that apply to you:
☐ Frequent headaches ☐ Dry eyes ☐ Allergies ☐ Sinus trouble
☐ Pregnant ☐ Given birth in the last 6 months

Please check any that apply to your social history:
Alcohol Use ☐ None ☐ Occasional ☐ Daily
Tobacco Use ☐ None ☐ Occasional ☐ Daily

Are you allergic to any medications? ☐ Yes ☐ No
If Yes, please list____

Please list all medications you are currently taking (Including any over the counter medications):

Have you ever had any of the following conditions involving your eyes?
☐ Eye surgery ☐ Eye injury ☐ Sensitivity to light ☐ Eye infection or disease_____☐ Double vision
☐ Eye strain ☐ Severe pain ☐ Poor distance vision ☐ Poor near vision ☐ Eyes burn, itch, or water

Do you currently wear glasses? ☐ Yes ☐ No
When do you wear your glasses?
☐ All the time ☐ Reading / near work ☐ Work safety
☐ Distance tasks only ☐ Computer work ☐ Other, please explain______________________________

Have you ever worn contacts? ☐ Yes ☐ No Are you interested in wearing contact lenses? ☐ Yes ☐ No
If so, what style?
☐ Soft ☐ Extended wear ☐ Gas Permeable ☐ Bifocal
☐ Astigmatic ☐ Disposable ☐ Tinted ☐ Unsure

PAYMENT IS DUE WHEN SERVICES ARE RENDERED WE DO NOT BILL

Please circle one of the following payment methods:
CASH.... CHECK.... VISA.... MASTERCARD.... DISCOVER

AUTHORIZATION
I authorize Dr. Graefe and/or his staff to release any information including the diagnosis and the records of any treatment or examination rendered to myself or my child during the period of such eyecare to third party payers and/or health practitioner, this may include any future request for glasses and or contact prescriptions.

X____
SIGNATURE OF PATIENT (Or parent if minor) **DATE**