Warrenton Eye Associates, P.C.

Dr. Heidi Calladine

Patient's Name (First & last):_____**Date**:_____

Home Address:_____

Date of Birth:_____ **Sex**: ☐ Male ☐ Female **Language**:_____

Race: ☐ White ☐ American Indian or Alaska Native ☐ Asian ☐ Other

☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline

Home Phone: _____ **Cell Phone**: _____

Work Phone: _____ **E-mail**: _____

Preferred method of Contact (Home phone, Cell phone, work phone or e-mail): _____

Employer: _____

Occupation: _____ **Hobbies**: _____

Social Security #: _____

Name of Vision Insurance: _____ Vision Policy #: _____

Name of Policy Holder & Relationship: _____

Policy Holder Date of Birth**:**_____ Group #: _____

Medical Insurance: _____ Medical Policy #: _____

Name of Policy Holder & Relationship: _____

Policy Holder Date of Birth: _____ Group #: _____

Policy Holder Address: _____

List any family members that are patients here: _____

Date of Last Eye Exam: _____ **Referred By**: _____

Reason for Today's Exam: _____

Do you wear Glasses: _____ **Do you wear Contacts**: _____ **Brand**: _____

GENERAL HEALTH HISTORY:
(Do you currently have any of the following)

Yes	No		Yes	No		Yes	No	
☐	☐	Respiratory (Asthma)	☐	☐	Allergic/Immunologic	☐	☐	Skin (Eczema/Rash)
☐	☐	Endocrine (Diabetes, Thyroid)	☐	☐	Muscles/Bones/Joints	☐	☐	Neurological
☐	☐	Blood/Lymph (Cholesterol)	☐	☐	Gastrointestinal	☐	☐	Fever
☐	☐	Kidney Disease	☐	☐	Ears/Nose/Throat	☐	☐	Weight Loss
☐	☐	Cardiovascular (High Blood Pressure, Heart)						

☐ Other (please list)_____

Past Illnesses/Injuries_____

Current Medications_____

Past Surgeries_____

Allergies (medicine/seasonal – please list): _____

☐ No Known Drug Allergies _____

Name of your Primary Care Physician: _____

Are you pregnant or nursing: Y / N

FAMILY HISTORY:

☐ Amblyopia (Lazy Eye)	Relation:_____	☐ Kidney Disease	Relation: _____
☐ Color Deficiency	Relation: _____	☐ Heart Disease	Relation: _____
☐ Macular Degeneration	Relation: _____	☐ Stroke	Relation: _____
☐ Retinal Detachment	Relation: _____	☐ Lupus	Relation: _____
☐ Blindness	Relation: _____	☐ Diabetes	Relation: _____
☐ Cataract	Relation: _____	☐ Arthritis	Relation: _____
☐ Glaucoma	Relation: _____	☐ Cancer	Relation: _____
☐ High Blood Pressure	Relation: _____	☐ Thyroid	Relation: _____

☐ Other
(please list)_____

SOCIAL HISTORY:
Do you drink alcohol? ☐ No ☐ Occasional ☐ One per day ☐ 2-3/day ☐ 4+/day
Do you smoke? ☐ No ☐ Occasional ☐ ½ pack/day ☐ 1 pack/day ☐ 1+ pack/day
Have you ever smoked? Y / N

Notice of Privacy Practices/HIPPA Authorization

By signing below you attest that you have been informed of / offered this practice's privacy policy and the rights to privacy that you are afforded by federal legislation (HIPAA Privacy Act). The privacy policy outlines how your information is shared only for the purpose of performing service or collecting payment. I am free to refer to this policy at any time. These policies are subject to change or modification as legislation changes.

I give permission to Warrenton Eye Associates to discuss or release health information identifying me to my insurance companies, referring / consulting physicians, and the following authorized people and Entities:
(Names :) _____

Patient/Guardian Signature: _____ Date: _____

Signature on File (Assignment of Benefits)

Your insurance is a method for you to receive reimbursement for fees you have paid to the optometrist for services rendered. Having insurance is not a substitute for payment. It is your responsibility to pay in advance for the deductible, coinsurance, or any other balances not paid for by your insurance. We will assist you in receiving reimbursement as much as possible, but you are responsible for your bill. By signing this you authorize payment of these benefits directly to Warrenton Eye Associates, PC on your behalf for any services and materials furnished.

I authorize Warrenton Eye Associates to bill my insurance companies for services provided to me and with payment made directly to the providing doctor's office and that such authorization is valid until written notice is provided to cancel that authorization.

Financial Responsibility

By signing this statement you agree to be financially responsible for all charges. We do not guarantee the accuracy of benefit information given to us by insurance companies. The financial responsibility for your account is yours, not your insurance companies. I understand that there is a $25 fee for all returned checks.

Authorization to Release Medical Information

I authorize any holder of medical information about me to release to Warrenton Eye Associates and its agent any information needed to determine benefits or the benefits payable for related services. This assignment will remain in effect until revoked in writing. A photocopy of this assignment is considered to be as valid as the original.

I have read and understand all of the above.

Patient/Guardian Signature: _____ Date: _____