InSight of the Wabash Patient Paperwork

Name: _____

Date of Birth: _____

Preferred Phone #: _____

Address: _____

City / State/ Zip: _____

E-mail: _____

Last 4 digits of Social Security #: _____

Occupation/Grade: _____

Employer/School: _____

Medical Insurance: _____

Vision Insurance: _____

Acknowledgment of Receipt

I acknowledge that I received a copy of the Notice of Privacy Practices. (A copy of HIPPA privacy practices will be available for you to have if requested at appointment).

Date: _____ Patient Name: _____ Signature: _____

***** May we release your glasses or contact lens prescription with your verbal approval to you or a third party of your choice? Y/N**
***** May we use your name, email and/or address to send you special offers from our office? Y/N**

Insurance Authorization

I request that payment of authorized Insurance benefits for any services furnished to me, be made on my behalf to: InSight of the Wabash

I authorize any holder of medical information about me to release my insurance company and its agents any information needed to determine these benefits or the benefits payable for related services.

I understand that I am responsible for charges not paid by the insurance plan.

Date: _____ Patient Name: _____ Signature:_____

Medical Information

Date of last eye exam: _____ Dilated ? Y/N
Have you had any eye operations? Y/N
Type: _____ Date: _____
Have you had an eye injury? Y/N
Type: _____ Date: _____
Do you have blurred vision? Y/N
When: _____
Any other eye problems? Y/N
Explain: _____
Do you wear glasses? Y/N
Contact Lenses? Y/N Type: _____

Height: _____
Weight: _____

Are you taking any medications? Y/N
If yes, please list below or provide list:

_____

_____

_____

Do you have any medication allergies? Y/N
If yes, what are you allergic to?

_____

_____

Family Physician: _____
Physician Phone # _____

Pharmacy Name: _____

Pharmacy Phone Number: _____

Emergency Contact: Name _____ Phone Number _____

Married _____ Single _____ Divorced_____ Other_____

Personal and Family

	Self	Mother	Father	Sister	Brother	Daughter	Son
Anxiety							
Asthma							
Atrial Fibrillation							
Cataracts							
Chronic Kidney Disease							
Congestive Heart Failure							
Coronary Artery Disease							
Depression							
Diabetes Mellitus, Type I							
Diabetes Mellitus, Type II							
Diabetes Mellitus, Unspecified							
End Stage Renal Disease							
Glaucoma							
Hyperlipidemia							
Hypertension							
Macular Degeneration							
Retinal Detachment							
Peripheral Vascular Disease							

Please list any other health issues not listed above:

_____

_____