Patient Packet

Patient Information & HIPAA

Name: _____ Date of Birth: _____

Address: _____ Last 4 Digits of SSN: _____

City / State/ Zip: _____ ☐ Male ☐ Female

Preferred Phone #: _____ ☐ Married ☐ Single

E-mail: _____

Do you have Medical Insurance? ☐ No ☐ Yes Insurance Name: _____

Do you have a Vision Plan? ☐ No ☐ Yes Plan Name: _____

Are you currently Employed? ☐ No ☐ Yes Employer: _____

Are you currently a Student? ☐ No ☐ Yes School / Grade: _____

Emergency Contact Information (NOTE: Please answer Yes or No beside each Contact)

Name	Relationship	Phone	OK to release information to Contact? (Circle Answer)
			Yes No
			Yes No
			Yes No

Insurance Authorization & Self-Pay Acknowledgement

I request that payment of authorized insurance benefits for any services furnished to me, will be made to **InSight of the Wabash** on my behalf.

I authorize **InSight of the Wabash** to release any of my medical information to my insurance company and its agents which may be needed to determine if benefits are payable for services rendered.

I understand that I am financially responsible for all charges NOT PAID by my insurance plan(s).
I understand that if I am a SELF-PAY PATIENT, I am responsible for all charges at the time of service.

_____ _____
Patient/Guardian Signature Date

Acknowledgment of HIPAA Policy

Our HIPAA Policy is on display in our office for you to view. We can give you a copy upon request.

I acknowledge that InSight of the Wabash provided access to their HIPAA Policy for me to view.

_____ _____
Patient/Guardian Signature Date

Patient Packet

Medical History - 1

Patient Name: _____

Date of last eye exam: _____ Were your eyes dilated? ☐ Yes ☐ No

Have you had any eye surgeries? ☐ Yes ☐ No
Type: _____ Date: _____

Have you had an eye injury? ☐ Yes ☐ No
Type: _____ Date: _____

Do you have blurred vision? ☐ Yes ☐ No
Explain: _____

Any other eye problems? ☐ Yes ☐ No
Explain: _____

Do you wear glasses? ☐ Yes ☐ No

Do you wear contact lenses? ☐ Yes ☐ No Type: _____

Height: _____ Weight: _____

Are you taking medications? ☐ Yes ☐ No If yes, please list below:

_____

_____

_____

_____

_____

_____

_____

Medication allergies? ☐ Yes ☐ No If yes, please list them below?

_____

_____

Primary Doctor: _____

Preferred Pharmacy: _____

Patient Packet

Medical History - 2

Patient Name: _____

Do you (or a family member) have any of these conditions?

Check appropriate boxes

	Self	Mother	Father	Sister	Brother	Daughter	Son	Other
Anxiety								
Asthma								
Atrial Fibrillation								
Cataracts								
Chronic Kidney Disease								
Congestive Heart Failure								
Coronary Artery Disease								
Depression								
Diabetes MellitusT-1								
Diabetes MellitusT-2								
Diabetes Mellitus Unspecified								
End Stage Renal Disease								
Glaucoma								
Hyperlipidemia								
Hypertension								
Macular Degeneration								
Peripheral Vascular Disease								
Retinal Detachment								

Please list any other health issues not listed above:

_____

_____

_____