Patient Information & HIPAA (Patient Packet)

Name: _____ Date of Birth: _____

Address: _____ Last 4 Digits of SSN: _____

City / State/ Zip: _____

Preferred Phone #: _____

E-mail: _____

☐ Male ☐ Female

☐ Married ☐ Single

☐ Other: _____

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 Signature or 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 Signature or Guardian Signature Date

Medical History (Patient Packet)

Patient Name: _____

Date of Birth: _____ Height: _____ Weight: _____

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: _____

Are you taking medications? ☐ Yes ☐ No

If yes, please list them below (or provide your own list):

_____

_____

_____

_____

_____

_____

_____

_____

_____

Do you have medication allergies? ☐ Yes ☐ No

If yes, please list them below (or provide your own list):

_____

_____

_____

Medical History (check appropriate boxes)		
Condition	**Personal**	**Family**
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		
Other Condition(s) not specified above		
Condition	**Personal**	**Family**

Primary Doctor: _____

Local Pharmacy: _____

Mail-Order Pharmacy: _____