EUROPE EYE CLINIC

Please take a few minutes to carefully fill out the following information. All information will be strictly confidential.

Patient's Name ____
Last First Middle

Address ____

City, State, Zip ____

Phone: Home ____________________ Work ____________________ Mobile ____________________

Occupation/Grade ____________________ Employer/School ____________________

Birth Date ________________ Male or Female ________ SS# (required for insurance billing) ________________

E-mail Address ____

Referred by: Family____ Friend____ Doctor____ Phone book____ Radio____ Insurance Co ____ Walk-in ____ Other____________

Name of the person we may thank for referral ____

I am here for: Routine Eye Exam___ Contact Lens Exam___ Medical Problem___ Eye Emergency___ Laser Surgery Evaluation___

MEDICAL HISTORY

Many health conditions and medications can affect your eyes; please check if your health history includes:
High blood pressure _____ Diabetes _____ Cancer____ Allergies ____ Arthritis ____ Eye surgery ____ Eye injuries ____
Any other unusual health problems not listed above?____
Are you taking any medication presently? Yes ____ No ____ If yes, list all medications ____________________

Date of Last Eye Examination ____________________ Name of Previous Eye Clinic____________________
Eyeglasses Used Currently Yes ___ No ___ Can you see with them very well? Yes___ No ___
Contact Lenses Used Currently Yes ___ No ___ If yes, what kind? ____________ Wearing time: how many hours or days________

INSURANCE

We can verify benefits and eligibility with most insurance companies. However verification is only a review of benefits, not a guarantee of payment by the insurance company. **Any balance your insurance company does not pay is your responsibility**.

Vision Insurance____________________ Subscriber____________________
ID #____________________ Group #____________________

Medical Insurance____________________ Subscriber____________________
ID #____________________ Group #____________________

Bill Payer Name____________________ SS#____________________ Birthday____________________

INSURANCE AUTHORIZATION AND FINANCIAL ARRANGEMENTS

I authorize payment of authorized insurance benefits to Dr. Edward Lee for services rendered. I authorize any holder of my medical information to release my insurance company and its agents any information needed to determine these benefits or benefits payable for related services.
Professional fees are due at the day of examination. One-half of material fees are required before ordering with the balance due at the time the materials are picked up or delivered. Method of payment CASH____CHECK____BANK CARD____

Signature____ Date____________________

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it. My medical information may be shared within this practice or with other health care professionals who may be consulted.

Signature____ Date____________________