Patient Information Sheet **Date: _____**

Please circle: Mr. Mrs. Miss. Ms. Dr. **Sex: M F**

Name: _____

Street Address_____

City/State/Zip_____

Phone: Home: _____Cell:_____Work:_____

Which phone number do you prefer to be contacted at: _____

E-Mail:_____

Age: _____ Date of Birth: _____SS Number: _____

Occupation: _____Employer:_____

Please circle: Single Married (spouse's name_____) Divorced Widowed

Primary Care Physician: _____ Date of last physical: _____

IF MINOR: Mother's name_____ Father's name_____

Insurance Carrier: _____Subscriber ID/Member #_____

Subscriber's Name: _____Subscriber's Date of Birth _____

Secondary or Vision Insurance Carrier: _____Subscriber ID # : _____

List all MEDICATIONS: _____

_____

List any ALLERGIES: _____

Tobacco use: Yes No If yes how much? _____

Alcohol use: Yes No If yes how often? _____

Preferred language: English if other please list: _____

Race: (please circle one) American Indian/ Alaska Native Asian Black/ African American

Hispanic Native Hawaiian/ Other Pacific Island White

Do you wear contact lenses? : Yes No If no, are you interested in them? : Yes No

Do YOU or anyone in your immediate FAMILY have a history of the following :

PLEASE CIRCLE SELF, If applies to you,

P = parent GP = grandparent S = sibling O = other in family

Diabetes	**SELF**	**P**	**GP**	**S**	**O**	**High blood pressure**	**SELF**	**Arthritis**	**SELF**
Macular degeneration	**SELF**	**P**	**GP**	**S**	**O**	**Respiratory problems**	**SELF**	**Stroke**	**SELF**
Retinal detachment	**SELF**	**P**	**GP**	**S**	**O**	**Thyroid problems**	**SELF**	**Headaches**	**SELF**
Glaucoma	**SELF**	**P**	**GP**	**S**	**O**	**Head/Eye Injury**	**SELF**	**Pregnant**	**SELF**
Lazy Eye	**SELF**	**P**	**GP**	**S**	**O**	**Heart problems**	**SELF**	**Nursing**	**SELF**
Blindness	**SELF**	**P**	**GP**	**S**	**O**	**Eye Surgery**	**SELF**		
Cataracts	**SELF**	**P**	**GP**	**S**	**O**	**Cancer**	**SELF**		

NEW Patients Only: Date of last eye exam: _____

How did you hear about our office: _____

Authorization for Release of Medical Information to the Payer and Assignment of Benefits to the Physician

I hereby authorize release of medical information necessary to file a claim with my insurance company and assign benefits otherwise payable to me to Dr. Shari Gustin, or Dr. Hochreiter. I understand that I am financially responsible for any balance not covered by my insurance carrier. A copy of the signature is valid as the original.

Signature of PATIENT (or guardian) : _____ Date : _____

Office Financial Policy:

All payments for services, procedures, and materials are expected on the day of appointment. If co-pay is not made at time of service, there will be a $10.00 fee added onto the balance due. There will be a fee of $30.00 on all returned checks. Please notify the office 24 hours in advance if unable to keep appointment or a $35.00 fee will be charged. If payment on a delinquent account has not been made within 90 days, the account will go into collections. In the event that your account is referred to a collection agency, you will be responsible for all fees incurred for the collection of your bill; this includes attorney fees, court costs, and collection agency fees. As a courtesy, we confirm your insurance benefits the day before your appointment. All insurances do not guarantee any information provided to us over the phone or by the internet. It is the patient's responsibility to be familiar with their insurance policy, covered and non-covered benefits as well as frequency and limitations of their coverage. Insurance companies select certain services that they will cover, as a result, not all procedures are covered by every insurance.
The patient/guardian is responsible for cost of eye care and/or eyewear not covered by insurance contract.

I have read and understand the above financial policy.

Signature of PATIENT (or guardian) : _____Date : _____