DATE: _____ **PATIENT FULL LEGAL NAME:** _____ ❑ M ❑ F ❑ 0

SOCIAL SECURITY# _____ **DATE OF BIRTH:** _____

ADDRESS: _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____

PHONE#: _____ **CELL#:** _____ **WORK#:** _____

EMAIL ADDRESS: _____ **MARITAL STATUS:** ❑ MARRIED ❑ SINGLE ❑ DIVORCED ❑ WIDOW

ETHNICITY (SELECT ONE): ❑ HISPANIC/LATINO ❑ NON HISPANIC/LATINO

RACE: (SELECT ONE) ❑ WHITE ❑ BLACK OR AFRICAN AMERICAN ❑ ALASKA NATIVE ❑ ASIAN

❑ AMERICAN INDIAN ❑ NATIVE HAWAIIAN ❑ PACIFIC ISLANDER ❑ DECLINE TO ANSWER OTHER _____

PRIMARY CARE PHYSICIAN: _____ **PHONE#:** _____

ENDOCRINOLOGIST/DIABETIC DR.: _____ **PHONE#:** _____

EMERGENCY CONTACT: _____ **PHONE#:** _____

Please list family members or friends who are authorized to speak to us about your health care issues.

NAME: _____ **RELATIONSHIP:** _____ **PHONE NUMBER:** _____

NAME: _____ **RELATIONSHIP:** _____ **PHONE NUMBER:** _____

It may be necessary for the office to leave a message for you regarding medical information such as test results, prescriptions, billing or account information, or other health care issues.

MAY WE LEAVE A MESSAGE ON YOUR:

HOME PHONE: ❑ **CELL PHONE:** ❑ **WORK PHONE:** ❑

I GIVE CONSENT FOR MY PHARMACY (PRESCRIPTION) RECORDS TO BE OBTAINED AND/OR TRANSMITTED: **INITIAL:** _____

PHARMACY NAME: _____ **ADDRESS:** _____ **PHONE NUMBER:** _____

LOCAL: ❑ **MAIL ORDER:** ❑

It is the responsibility of each patient to determine which services are covered by their individual plan(s) prior to appointments, as insurance coverage and reimbursement is determined by your plan. Medical and Vision plans vary in coverage. VSP covers only a routine vision exam, while medical conditions such as glaucoma, retinopathy, cataracts, etc, must be filed as a medical diagnosis to your major medical insurance. If you have a HMO, a referral from your primary care physician is required prior to your medical eye appointment. The refraction fee (a non-covered service under the majority of medical plans), along with co-pays, deductibles, any other non-covered service, and coinsurance must be paid at time of service. Any charges not paid at time of service will incur a $10 fee, any charges billed and not paid in full over 60 days will incur a $25 late fee. **INITIAL:** _____

RELATIONSHIP TO PATIENT: _____ (If other than self)

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT OF RECEIPT

I acknowledge that I was offered a copy of the Fox Valley Ophthalmology's Notice of Privacy Practices.

PATIENT NAME: _____ **DATE:** _____

SIGNATURE: _____

IF NOT PATIENT STATE RELATIONSHIP: _____