DATE: ______________________ PATIENT FULL LEGAL NAME: ____ ❑ M ❑ F ❑ O

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: _________________________________ STREET/CITY: ____

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: ____