PATIENT INFORMATION FORM

Name: _____ Home Phone: (_____)_____-_____
Address:_____ Cell Phone: (_____)_____-_____
City/State:_____ Emergency Phone: (_____)_____-_____
Zip code:_____ Email:_____
Sex: M☐ F☐ Date of Birth: ____/____/____ Age: _____
Social Security # _____-_____-_____ Height:_____
Weight:_____
Occupation/Grade: _____ Employer/School:_____
Is there anyone, besides yourself, that we may discuss your medical information with?
If so, please list:

_____
Have we seen other family members? _____
Whom may we thank for referring you?_____
How would you prefer to receive future correspondence (please circle)? Text Email Phone

INSURANCE

Medical Insurance Company_____ Policy #_____ Group #_____
Name of Insured: _____ Relationship to Patient: _____
SS# of Insured: _____ DOB of Insured: _____

Vision Insurance Company_____ Policy #_____ Group #_____
Name of Insured: _____ Relationship to Patient: _____
SS# of Insured: _____ DOB of Insured: _____

Assignment of Release of Insurance:

I certify that I, and/or my dependent(s) have insurance coverage with _____ and assign directly to Dr. Ashley E. Bradford all insurance benefits, if any, otherwise payable to me for services rendered, I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.
The above-named doctor may use my health care information and may disclose such information to the above-named insurance company(s) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable to related services. Claims will be filed by HCFA or electronically.

Print Name: _____

Signature: _____

Date: _____

Relationship to Patient:_____

MEDICAL HISTORY

Last Eye Exam: _____ Name of Doctor: _____
Do you wear glasses? Yes No Do you wear contacts? Yes No
Primary Care Doctor: _____ Date of last visit:_____
Pharmacy:_____
Are you pregnant?_____ Nursing? _____ Alcohol use? _____ Tobacco Use? _____

Please check any condition that applies to yourself or any members of your immediate family.

	Self	Family
Diabetes	☐	☐
High Blood Pressure	☐	☐
Heart Problems	☐	☐
Breathing Problems	☐	☐
Thyroid Problems	☐	☐
Headaches	☐	☐
Cancer	☐	☐
Hepatitis (type____)	☐	☐
AIDS/HIV	☐	☐
Arthritis	☐	☐
Blurred Vision	☐	☐
Eye Stain	☐	☐
Double Vision	☐	☐
Head/Eye Injury	☐	☐
Watery Eyes	☐	☐

	Self	Family
Floaters/ Spots	☐	☐
Flashes of Light	☐	☐
Itching Eyes	☐	☐
Glaucoma	☐	☐
Cataracts	☐	☐
Macular Degeneration	☐	☐
Retinal Detachment	☐	☐
Eye Surgery	☐	☐
Lazy Eye	☐	☐
Crossed Eyes	☐	☐
Blindness	☐	☐
Red Eyes	☐	☐
Eye Infection	☐	☐
Dry Eyes	☐	☐
Light Sensitivity	☐	☐
Temporary Vision Loss	☐	☐

Other ailments or diagnosis not listed above:

_____

_____

Do you have any drug /seasonal allergies? If so, Please list:

_____

List any current medications you are currently taking, including eye drops:

_____

_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

The full notice of privacy practices of Haughton Vision, LLC is available by request from our check in desk and is also available online at www.haughtonvision.com. I have read (or had the opportunity to read if I so chose) and understand the notice.

Patient Name (Please Print): _____ Date:_____

Patient or Authorized Representative (if applicable):_____

Signature_____