PLANO EYE Associates-East

the WRIGHT eyewear

Thank you for choosing our office for you eyecare needs. We are glad to help with any questions or concerns.
All Patient information is confidential.

Patient Name: Date:

Address: City/State: Zip:

Home Phone: Cell Phone: Text OK? Y or N

Work Phone: Email:

Patient SSN: Date of Birth: Marital Status:

Occupation: Employer:

Preferred Pharmacy: Phone #:

Communication Preference: ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Email

Ethnicity: ☐ African American ☐ American Indian/Alaskan Native ☐ Asian
☐ Caucasian ☐ Hispanic ☐ Native Hawaiian/Pacific Islander

Vision Insurance: ID# Primary's SSN#

Medical Insurance: ID# Primary's DOB:

Secondary Medical: ID# Primary's Name:

Insurance and Payment Authorization: We need copies of **both** Medical **AND** Vision.

I request that payment for services rendered to be made on my behalf to Plano Eye Associates- East. I authorize the release of information required to process any insurance claims. I permit my signature and/or the policy holder's signature along with copies of cards to be kept on file for future visits and insurance claims indefinitely.

I understand that with the varying nature of vision and health insurance policies, there may be additional fees or eligibility denials that my insurance dictates upon the initial filing of the claim from Plano Eye Associates-East. I understand and agree that I (or the guarantor) am financially responsible for any and all charges insurance does not cover regardless of benefits quoted. I understand that all outstanding balances will accrue a late fee if arrangements are not made, and accounts over 90 days may be forwarded to a collection agency.

Signature: Date:

Health History

Do you wear glasses? Y or N For?: Distance Near Computer All

Do you wear contacts? Y or N If no: Are you interested in contacts? Y or N

Please check any of the following conditions that apply to you:

□Smoke □Pregnant □Frequent Headaches □Alcohol/day _____ □Drugs_____

Please list all medications and/or vitamins you are taking:_____

_____

_____

Please list all medications you are allergic to and the reaction:_____

_____

History of you or blood relative having any of the following:

	N/A	Self	Relative		N/A	Self	Relative
Macular Degeneration				Glaucoma			
High Blood Pressure				Blindness			
Cataracts			n/a	Diabetes			
Eye Infections			n/a	Lazy/Turned Eye			
Headache/Migraines			n/a	Eye Injury/Surgery			n/a
Retinal Detachment				Other			n/a

Do you currently have, or have you this year had:

□Itching □Watering □Dryness □Allergies □Redness

Do you use rewetting or allergy drops? Y or N. If Yes _____

How did you hear about our practice? Name: _____

□Friend □Co-Worker □Insurance Provider □Relative □Other_____

Acknowledgement of Receipt

I acknowledge that I have read or have had the opportunity to read the Notice of Privacy Practices available at the front desk or online).

Patient Name (Printed) _____Date:_____

Signature of Patient or Guardian:_____