Welcome to Panhandle Vision Institute

Last Name: _____ First Name: _____ Middle: _____

Address: _____ City: _____ State: _____ Zip: _____

Parent/ Guardian: _____ DOB: _____

Date of Birth: _____/_____/_____ Age: _____ Social Security #: _____ ( ) Male ( ) Female

Home Phone: ( ) ____-_____ Cell: ( ) ____-_____ Email: _____@_____

( ) Single ( ) Married ( ) Widowed ( ) Other Race: _____ Ethnicity: _____

Employer: _____ Occupation: _____

How did you hear about u, or by whom where you referred? _____

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Medical Insurance Carrier: _____Primary Holder: _____DOB_____

Insurance ID #: _____ Insurance Group #: _____ Relationship to Patient: _____

Secondary Insurance Carrier: _____Primary Holder: _____DOB_____

Insurance ID #: _____ Insurance Group #: _____ Relationship to Patient: _____

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AUTHORIZATION: PLEASE READ & SIGN BELOW

I certify I have read and understand the above information and have answered accurately to the best of my knowledge. I authorize the doctor to release any information including diagnosis and records of treatment or examinations rendered to me or my child during the period of such eye care to 3rd party payers and/or health practitioners. I authorize & request my insurance company to pay directly to the eye doctor or group insurance benefits otherwise payable to me. I understand my insurance may pay less than the actual billed amount for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____ _____ _____

Signature of patient or Guarantor Relationship if not patient Date

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Consent of Treatment: I hereby grant MY authorization and consent for medical treatment and procedures for myself and/or minor children and certify that no guarantee or assurance has been made as the results which may be obtained.

_____ _____ _____

Signature of patient or Guarantor Relationship if not patient Date

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AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____ , authorize PVI doctors and staff to disclose information regarding my medical treatment and diagnosis and information regarding my financial account with the following designated individuals or organizations.

_____

Name of person or persons you authorize release of information to (Another doctor's office or a family member)

_____ _____ _____

Signature of patient or Guarantor Relationship if not patient Date

RIGHT TO TERMINATE OR REVOKE AUTHORIZATION you may revoke or terminate this authorization by submitting a written revocation to Panhandle Vision Institute

MEDICAL & OPTICAL PROFILE

Primary Care Physician: _____

Personal & Family Medical History: *(if you are an established patient and there are NO CHANGES skip medical history portion)*

	Self		Family			Self		Family	
Allergies	Yes	No	Yes	No	**Migraines**	Yes	No	Yes	No
Arthritis	Yes	No	Yes	No	**Stroke**	Yes	No	Yes	No
Asthma/COPD	Yes	No	Yes	No	**Thyroid Disease**	Yes	No	Yes	No
Cancer	Yes	No	Yes	No					
Diabetes	Yes	No	Yes	No	**Cataracts**	Yes	No	Yes	No
Elevated Cholesterol	Yes	No	Yes	No	**Eye Injury**	Yes	No		
Heart Attack	Yes	No	Yes	No	**Eye Surgery**	Yes	No		
Heart Disease	Yes	No	Yes	No	**Glaucoma**	Yes	No	Yes	No
High Blood Pressure	Yes	No	Yes	No	**Macular Degeneration**	Yes	No	Yes	No

Current Medications (RX and Over the counter):
Name of Medication:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

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Panhandle Vision Institute is committed to caring for our patient's complete ocular health. Here at PVI, our patients will receive a **COMPLETE EYE HEALTH EXAMINATION**. Our doctors are specially trained to diagnose and treat all ocular diseases.

As a courtesy to our patients, we are happy to file with your insurance company. NOTE: The patient is responsible for any co-pays and/or deductibles which your insurance requires before services are rendered.

When a medical condition (cataracts, glaucoma suspect, glaucoma, diabetes, pink eye-conjunctivitis, foreign body, macular degeneration, dry eyes, etc.) is determined by our doctors, PVI will bill your Health (Medical) Insurance on your behalf. We request a copy of your medical insurance card in your chart for these reasons.

Routine Vision exams will be conducted with our partners at Sight and Sun Eyeworks and will be filed with your Vision Plan if you have one. A routine exam means there is not a ***medical diagnosis***. Routine diagnoses are myopia (near-sightedness), hyperopia (far-sightedness), astigmatism and presbyopia.

Thank you,
The Doctors and Staff of PVI

I have read and understand when and how my insurance plans will be filled.

_____ _____

Signature **Date**