**Patient Update Form**

|  |
| --- |
| Name: Are you a new patient?  |
| Date of birth: Social security:  |
| Address: |
|  |
| Cell phone number: Home/Alt phone number: |
| Email address: |

**Primary Insurance Policy Holder Information**

|  |
| --- |
| Name: |
| Date of birth: Social security:  |
| Vision Insurance: Medical Insurance:  |

**Additional Information**

|  |
| --- |
| Emergency contact: Relationship to patient:  |
| Emergency contact phone: |
| Primary care doctor and clinic:  |
| Pharmacy: |

* Are you interested in glasses or contacts today?
* Please circle GLASSES CONTACTS BOTH
* I understand that if I choose to have contacts that I may owe an additional fee for the contact lens fitting: Please initial here:\_\_\_\_\_\_\_\_\_
* Have you worn contacts before? Please circle YES NO
* I understand that my prescription is valid for 1 year following my exam. Initial here: \_\_\_\_\_\_\_\_\_\_

**PLEASE TURN FORM OVER FOR MEDICAL INFO AND SIGNATURES 🡪**

**Medical Information**

Are you allergic to any medications? If so please list them below:

|  |
| --- |
|   |
|  |

Please list medications below:

|  |  |
| --- | --- |
|  |  |
|  |  |
|  |  |

**History: Please Circle All That Apply**

Type 1 Diabetes

Type 2 Diabetes

Pre-Diabetic

High Blood Pressure

Stroke

Cataract Surgery

Osteoarthritis Rheumatoid Arthritis

Other Autoimmune Condition\_\_\_\_\_\_\_\_\_\_\_\_

Glaucoma

Macular Degeneration

Migraines

Other Neurological Condition\_\_\_\_\_\_\_\_\_\_\_\_

Alcohol Use

Smoking

Currently pregnant

**Please Read the Following & Sign**

I understand that I may owe an additional fee or copay for any additional testing ordered by the optometrist. Fundus Photos, Visual Field Tests, and Corneal Measurements are not considered “routine” and therefore are not covered under a routine eye exam insurance benefit. Please initial here: \_\_\_\_\_\_\_\_\_

I authorize release of medical information. This authorization shall be binding indefinitely from the date of signature. A copy of this release will be as legal and binding as the original.

I understand that all office visits are to be paid at the time services are rendered. I also realize that I am responsible for payment before filing my insurance. For any services rendered I request that payment of authorized Medicare, Medicaid, and or insurance benefits be made to Northside Eye Care. I authorize any holder of medical or other information about me to release to Health Care Financing Administration, insurance company and its agents any information needed to determine these benefits or benefits for related services. I authorize my signature to be transferred to my Dr. Chrono electronic health record for use by Northside Eye Care.

Due to danger to myself and others, I realize I should exercise caution or abstain from driving while my eyes are dilated, medicated, or patched.

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_