

# Apple Optometry Patient Information

Today's Date: \_\_\_\_\_ Referred By: \_\_\_\_\_

## **Patient Information:**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_ Apt # \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_\_) \_\_\_\_\_

\_\_\_\_ check here if you would like to opt in for text message notifications

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Sex: **M F**

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

E-mail: \_\_\_\_\_@\_\_\_\_\_

\_\_\_\_ check here if you would like to opt in for email notifications

Driver's License Number: \_\_\_\_\_ Exp \_\_\_\_/\_\_\_\_/\_\_\_\_ Issue State \_\_\_\_\_

**Married   Legally Separated   Single   Widowed   Minor   Divorced   Domestic Partner**

## **Insurance Information:**

**Medical Insurance Plan:** VSP   Eye Med   Spectera   Davis   MES   Care Credit   Flex Spending

Other: \_\_\_\_\_

**Primary Insured's Name:** \_\_\_\_\_

**Primary Insured's DOB:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Primary Insured's Soc. Sec#** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Primary Employed with** (name of company): \_\_\_\_\_

**Relation to Patient:** \_\_\_\_\_

Group Number/ Member Number/ ID Number \_\_\_\_\_

Provider's Phone Number (\_\_\_\_\_) \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone Number \_\_\_\_\_

Medical Insurance Provider: \_\_\_\_\_

Group Number/ Member Number/ ID Number \_\_\_\_\_

Provider's Phone Number (\_\_\_\_\_) \_\_\_\_\_

## **Employment History of Patient:**

Employed By: \_\_\_\_\_ Occupation: \_\_\_\_\_

Business Address: \_\_\_\_\_ Suite # \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip Code: \_\_\_\_\_

Business Phone: \_\_\_\_\_ Business Fax: \_\_\_\_\_

# Apple Optometry Health Questionnaire

Name: \_\_\_\_\_ Age: \_\_\_\_\_

## Emergency Contact:

Name of Person: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Apt # \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

## Do you have?

(Place a check in the box near any health problems you may have)

<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> Asthma	<input type="checkbox"/> Sjogren's	<input type="checkbox"/> Colitis
<input type="checkbox"/> Psoriasis	<input type="checkbox"/> Systemic Lupus	<input type="checkbox"/> Crohn's Disease
<input type="checkbox"/> Depression	<input type="checkbox"/> Auto Immune Disease	
<input type="checkbox"/> Herpes	<input type="checkbox"/> Thyroid Disease	

Do you have any other medical conditions? \_\_\_\_\_

Are you Pregnant? **Y** **N**                      Nursing? **Y** **N**

Have you seen any **FLASHES** or **FLOATERS** in your vision? **Y** **N**    Circle which one: **Flashes**    **Floaters**

Have your pupils ever been dilated?    **Yes**    **No**    When: \_\_\_\_\_

Have you had any eye surgery?    **Yes**    **No**    When: \_\_\_\_\_

Are you taking any **medication/vitamins/eye drops**? \_\_\_\_\_

Are you **Allergic** to any medication? \_\_\_\_\_

Are you wearing contact lenses now?    **Y**    **N**            If yes, what kind?    **Hard** (RGP) or **Soft** ?

What is the **BRAND** name of the **SOFT** contact lens? \_\_\_\_\_

When did you last wear your contact lenses? \_\_\_\_\_

Do you sleep with your contact lenses on?    **Y**    **N**

What type of cleaning solution are you using? \_\_\_\_\_

How old is the prescription in your glasses? \_\_\_\_\_ Contacts? \_\_\_\_\_

**I agree to pay in full for services rendered or materials purchased in case my insurance company denies coverage. I authorize the payment of medical benefits to the physician or supplier for the services rendered. I authorize the release of any medical or other information necessary to process the claim. I also request payment of government benefits to the party who accepts assignment.**

**Patient's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Parent's Signature** \*(If Under age 18) \_\_\_\_\_ **Date:** \_\_\_\_\_

# HIPAA

## Privacy Practices Acknowledgment & Authorization to Contact Patient/Record of Disclosures

I have read Apple Optometry's Notice of Privacy Practices, detailing how my information may be used and disclosed as permitted under federal and state law. I have been provided an opportunity to review the notice and I fully understand it. I request the following restriction(s) concerning the use of my personal medical information **(Please List ALL that applies):**

\_\_\_\_\_

I understand that Apple Optometry is not required to agree to the restrictions requested. Further, I permit a copy of this authorization to be used in place of the original.

The HIPAA Privacy rule gives patients the right to request a restriction on uses and disclosures of their protected health information. The patient is also provided the right to request confidential communication or that a communication of the protected health information to be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner **(Check all that applies):**

- Home Telephone Number: ( \_\_\_\_\_ ) \_\_\_\_\_
- OK to leave message with detailed information
- Leave a message with call back number only
- Cell Phone Number: ( \_\_\_\_\_ ) \_\_\_\_\_
- OK to leave message with detailed information
- Leave a message with call back number only
- Opt – In for Text messaging \_\_\_\_\_ (int) msg and data rates may apply depending on your carrier
  
- Work Telephone Number: ( \_\_\_\_\_ ) \_\_\_\_\_
- OK to leave message with detailed information
- Leave a message with call back number only

### Written Communication

- E-mail address: \_\_\_\_\_
- [You can elect
- OK to mail to my home address
- OK to mail to my work/office address
- OK to fax to: \_\_\_\_\_

*You and we agree to submit any dispute arising under this agreement, except a dispute alleging criminal violations, to arbitration in accordance with the Uniform Rules for Binding Arbitration of the Better Business Bureau of the Southland (published online at [www.labb.org](http://www.labb.org)) in effect at the time of initiation of arbitration. A volunteer arbitrator will render a decision based on fairness, not necessarily upon legal principles, but it will be final and binding on both of us. Judgment on the decision may be entered in any court having jurisdiction. You will not have to pay anything for the arbitration.*

*This Agreement to Arbitrate affects important legal rights. Neither of us will be able to go to court for disputes once we agree in advance to arbitrate. And neither of us will be committed by the terms of this agreement to arbitrate unless this clause is initialed or unless your signature on this contract as a whole immediately follows this clause. Further information about BBB arbitration may be obtained by calling the Better Business Bureau in Colton at (909)825-0490.*

\_\_\_\_\_ (Initials of Customer)

**Print Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Parent Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

\*(If under 18 years of age)