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)

______**Diabetes**	_______ **High Blood Pressure**	_______ **Rheumatoid Arthritis**
______**Asthma**	_______ **Sjogren's**	_______ **Colitis**
______**Psoriasis**	_______ **Systemic Lupus**	_______ **Crohn's Disease**
______**Depression**	_______ **Auto Immune Disease**	
______ **Herpes**	_______**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):**

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

- o Work Telephone Number: (__________) ________________________
- o OK to leave message with detailed information
- o Leave a message with call back number only

Written Communication

- o E-mail address:_____________________________________

[You can elect

- o OK to mail to my home address
- o OK to mail to my work/office address
- o 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) 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)

I, _____________________, hereby grant **Apple Optometry and 20/20 Optometric Eye Care or any affiliates** permission to take photographs of myself/children/family members and to publish those photographs for any lawful purpose, including, but not limited to, their website, social media accounts, and promotional materials, either digital or in print, in perpetuity. I also grant permission to use my name.

By signing and dating this document I authorize Apple Optometry and 20/20 Optometric Eye Care or any affiliates to edit, share, remix, tweak, build upon or in any way alter the photograph(s) mentioned above. I also waive any rights of privacy or compensation associated with the use of my image(s) and name(s) for the personal or commercial purposes outlined above.

Date______________________

Name_____________________

Signature__________________