Family Eye Care of Wooster

Patient Questionnaire

Today's Date _____

Mr. Mrs. Ms. Dr. _____ Date of Birth _____

Address _____City/State/Zip _____

Home Phone _____ Work/Cell Phone _____ SSN _____

Email _____ Marital status _____

Race: □American Indian or Alaska Native
□ Asian □White
□ Black or African American
□ Native Hawaiian/Other Pacific Island

Ethnicity □ Hispanic or Latino
□ Native Hawaiian/Other Pacific Island
□ Not Hispanic or Latino

Date of Last Eye Exam _____Doctor _____

Date of Last Physical _____ Doctor_____

Current Occupation: _____ Employer_____

Hobbies: _____

Who may we thank for referring you to our office? _____

If you were not referred, how did you hear about our office? *Check all that apply*

□Yellow Pages □Insurance List □Daily Record
□ Bargain Hunter □Web Site □Other_____

Check any of these things that apply to you:

□Work on a computer a lot □Spend many hours a day outside □Have times when you don't want to wear glasses
□Bothered by glare □Have a pair of prescription sunglasses □Interested in trying contact lenses
□Have trouble driving at night □Need a pair of safety glasses □Interested in refractive surgery (LASIK)

Insurance Information

** In order to process claims efficiently, **all** insurance information must be presented at time of service.*

Name of Vision Insurance_____

Subscriber's Name _____

Subscriber's Date of Birth _____

Subscriber's SSN _____

Name of Medical Insurance _____

Subscriber's Name _____

Subscriber's Date of Birth _____

Subscriber's SSN _____

Name of person responsible for today's payment: _____

I request that payment of authorized insurance benefits be made payable on my behalf to Family Eye Care of Wooster, LLC for any services rendered. In addition, **I understand that I am responsible for any co-payments or deductibles required by my insurance as well as any remaining balance *not* paid by my insurance**. Only the insurance companies named above will be billed for services and materials.

Signature _____ Date _____

HIPAA Privacy Acknowledgement of Receipt of Notice of Privacy Practices:

I, _____ [*Please print full legal name*], have been presented with the Notice of Privacy Policy (the "Policy") of Family Eye Care of Wooster, LLC, and have been offered a copy of such policy to keep for my records.

Signature _____ Date _____