WELCOME TO ADVANTAGE EYE CARE

ACCOUNT NUMBER

Patient's Name: **(Last, First, Middle Initial)**	☐ Male ☐ Female	Age:	Date Of Birth: (M/D/Y) / /
Email Address:	Patient's Social Security #: _____ - _____ - _____	Phone Number: ☐ Home ☐ Cell	
Street Address, APT # , City, State, Zip:			
Employer Name:		Occupation:	
Parent\Guardian Name (if under 18)			Date Of Birth: (M/D/Y) / /

Please tell us which of the following influenced you to choose Advantage Eye Care?

☐Friend/Relative ☐Internet ☐Insurance ☐Advertisement ☐School ☐Other:_____

Please list the media source or name of friend / relative that referred you to us._____

Insurance Information:

Patient's Relationship To Insured: ☐Self ☐Spouse ☐Child ☐Domestic Partner ☐ Other_____

Insurance Companany: _____ Phone Number: _____

Insurance Company Address: _____

Group Number: _____**Policy Number / Member ID: _____**

***Insured's Name*: _____ _____ _____**
Last ***First*** ***Middle Initial***

Insured's Date of Birth: ***(M/D/Y)*** _____/_____/_____ ***Insured's Social Security #:***_____ - _____ - _____

***Insured's Phone Number*: _____ *Insured's Employer*: _____**

Insured's Address: _____

I verify the information I have provided is true and correct. I authorize the release of any medical, identifying or other information necessary to process this claim. I also authorize release of payment to Advantage Eye Care for any services rendered.

Signature:_____ Date: _____/_____/_____

Prescription Release & Agreement To Hold Harmless

I give Advantage Eye Care permission to when requested by myself or on my behalf from a 3rd party to release my prescription information to requesting party by phone, fax, mail, electronic mail or physical copy. I understand that any transmission of my information may not be secure. I will not hold Advantage Eye Care liable for any intercepted or misinterpreted transmitted information and accept the risk.

Signature:_____ Date: _____/_____/_____

I HAVE REVIEWED THE INFORMATION ABOVE AND VERRIFY THAT IT IS TRUE AND CORRECT
(For every new visit, make any changes needed & sign initials and date on one of the following spaces provided)

_____ _____ _____ _____ _____ _____

PATIENT HEALTH HISTORY QUESTIONAIRE

IMPORTANT: Complete this form to the best of your abilities. Review and correct any changes before each and every exam

LAST NAME	FIRST NAME	DATE OF BIRTH

CHIEF COMPLAINT: (Why you are here today)

Do You Or Have You Ever Worn Eyeglasses?	**YES**	**NO**	**HOW LONG:**
Do You Or Have You Ever Worn Contact Lenses?	**YES**	**NO**	**TYPE & HOW LONG:**
Have You Ever Had Any Eye Surgery or Treatments?	**YES**	**NO**	**DATE, TYPE, &DR.:**

Do you or have you experienced any of the following?

Blurred Vision	**YES**	**NO**	**Flashes**	**YES**	**NO**	**Dry Eyes**	**YES**	**NO**
Pain In/Around Eyes	**YES**	**NO**	**Floaters**	**YES**	**NO**	**Headache**	**YES**	**NO**

MEDICATIONS & ALLERGIES:

List medications you take:

List any allergies:

DIABETIC HISTORY:

Do you have diabetes? **YES** **NO**

If yes, which type: **Type I** **Type II** **Prediabetes**

Any family members with diabetes? Mother Father Grandmother Grandfather

Has your managing Doctor requested reports? **YES** **NO**

Clinic: _____ **Phone #** _____

Doctor: **Fax #**

DO YOU OR ANY FAMILY MEMBERS HAVE ANY KNOWN HISTORY OF THE FOLLOWING:

HIGH BLOOD PREASURE	**YES**	**NO**	*Self*	*Mom*	*Dad*	*Grandma*	*Grandpa*	**CATARACTS**	**YES**	**NO**	*Self*	*Mom*	*Dad*	*Grandma*	*Grandpa*
GLAUCOMA	**YES**	**NO**	*Self*	*Mom*	*Dad*	*Grandma*	*Grandpa*	**BLINDNESS**	**YES**	**NO**	*Self*	*Mom*	*Dad*	*Grandma*	*Grandpa*
MACULAR DEGENERATION	**YES**	**NO**	*Self*	*Mom*	*Dad*	*Grandma*	*Grandpa*	**RETINAL DETACHMENT**	**YES**	**NO**	*Self*	*Mom*	*Dad*	*Grandma*	*Grandpa*

PREGNANCY INFORMATION:

Are you pregnant? **YES** **NO**	**How far along?**	**Date of birth or end of pregnancy:**

ADVANTAGE EYE CARE PAYMENT, ORDER & COLLECTIONS POLICY

Payment of Co-Pays & for professional services is required at the time the service is rendered. A deposit of a minimum of 50% is required before Ophthalmic materials will be ordered with the balance to be paid in full within 30 days or at the time of dispensing whichever comes first. When an order is complete, a phone call will be made to notify the individual that it is ready to be picked up. If possible, a message will be left. If we receive no response within 30 days and the order is still here it will be returned to stock. All orders left over 90 days will be considered abandoned and will be forfeited without notice. Regardless of the time an order is held for pick up I understand that I will be financially responsible for all of Advantage Eye Care's non-recoverable costs associated with completing the abandoned order. This may include but not limited to such charges as outside lab work costs, shipping charges and or a 15% re-stocking fee.

When Advantage Eye Care bills your insurance company, it is a courtesy to you and our regular and usual customary fees apply. Sale or promotional pricing cannot be combined with nor billed to insurance companies. Should insurance fail to submit payment, I agree that I will be obligated to pay for all materials and services provided to me or for the individual for whom I have Legal Responsibility. I fully understand that it is my responsibility to provide Advantage Eye Care with correct/updated and complete insurance information.

I agree to pay all amount(s) owed within 30 days of when such amount(s) incurred. However, regardless of insurance coverage, I agree that it is my responsibility to pay any and all amounts owing as set forth herein. I agree that interest will accrue on all past-due amounts at the rate of 18% annum (1.5% per month) until paid in full. In the event that any amount(s) is/are referred to a third-party debt collection agency, I agree that in addition to any other amount(s) allowed for by law, (such as interest, court costs, reasonable attorney's fees, exc.) I will also be responsible for a collection fee of up to 40% of the principal amount(s) owing as allowed by Utah Code Annotated, sec. 12-1-11. The terms of this paragraph shall apply to all amount(s) incurred by me or by any individual for whom I have legal responsibility whether such amount(s) are incurred today or after today.

I _____ agree to the above policies set forth by Advantage Eye Care.
(Print Name)

SIGNATURE:_____**DATE:**_____