THE VISION CENTER

NAME OF PERSON BEING EXAMINED____

STREET ______________________________________CITY & ZIP______________________

DATE OF BIRTH________________EMPLOYER___________________________OCCUPATION_______________

HOME PHONE______________________CELL________________________SSN______________________

E-MAIL ADDRESS____

PERSON RESPONSIBLE FOR BILL (IF DIFFERENT FROM PATIENT)_________________________________

ADDRESS & PHONE____

NAME, DATE OF BIRTH & SSN OF PERSON WHO CARRIES INSURANCE____

PLEASE CHECK APPRORIATE ANSWER (ASSUMING YOU ARE PROPERLY WEARING YOUR CORRECTION)

	YES	NO
DIFFICULTY WITH DISTANCE VISION	___	___
DIFFICULTY WITH NEAR VISION	___	___
FAMILY HISTORY OF GLAUCOMA	___	___
FAMILY HISTORY OF BLINDNESS	___	___
FAMILY HISTORY OF DIABETES	___	___
FAMILY HISTORY OF CATARACTS	___	___
SIGNIFICANT EYE PAIN	___	___
FREQUENT HEADACHES	___	___
EVER HAD EYE DISEASE	___	___
EVER HAD EYE SURGERY	___	___
USE ANY EYE DROPS	___	___

	YES	NO
EVER WORN EYEGLASSES	___	___
EVER WORN CONTACTS	___	___
BOTHERED BY BRIGHT LIGHTS	___	___
PERMANENT EYE DAMAGE	___	___

DATE OF LAST EYE EXAMINATION ___________

CURRENT MEDICATIONS/HEALTH PROBLEMS

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____

YOUR SIGNATURE ON THIS FORM WILL SERVE AS "SIGNATURE ON FILE" FOR BILLING ANY INSURANCE FOR YOU. THIS WILL ALLOW YOUR INSURANCE PAYMENTS TO BE MADE DIRECTLY TO OUR OFFICE. I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR ANY CHARGES NOT COVERED BY INSURANCE.

SIGNATURE (GUARDIAN IF MINOR)_______________________________________ DATE__________________

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

By signing this form, you acknowledge that Dr. David L. DePugh has given you a copy of the Privacy Notice which explains how your health information will be handled in various situations. We must have you sign this form on your first date of service with us after April 14, 2003.

If your first date of service with us was due to an emergency, we must try to give you this notice and get your signature acknowledging receipt of this notice as soon as we can after the emergency.

Check all that are true:

[ ] I have received Dr. David L. DePugh's privacy notice.

[ ] Dr. David L. DePugh has given me the chance to discuss my concerns and questions about the privacy of my health information.

Patient Signature____ Date______________________

Dr. David L. DePugh's staff should complete if Acknowledgement Form is not signed:

Does patient have a copy of the Privacy Notice?

[ ] Yes [ ] No

Please explain why the patient was unable to sign and acknowledgement for and Dr. David L. DePugh's efforts in trying to obtain the patient's signature:____

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