CAROLINA
OPTOMETRY ASSOCIATES

Patient Information

Salutation*(Mr, Mrs, etc)*_____**First Name**_____**MI**_____**Last Name**_____*(Jr, Sr, etc)*_____

Date Of Birth:_____ **Sex** (circle) M F

Address_____**City**_____**State**_____ **Zip**_____

Communication Preference (circle) Home Work Cell Email Text Postal

Phone #_____ **Email Address**_____

Insurance Information

Insurance Company_____ **Member ID Number**_____

Primary Insured_____ **Relationship to Patient**_____ **Primary DOB**_____

FOR VSP PATIENTS ONLY, Last 4 digits of primary's social (this is used as member ID #): _____

Acknowledgment of Insurance and Payment for Services

- If insurance is filed on my behalf, I authorize my insurance benefits to be paid directly to Carolina Optometry Associates, P.A.
- I agree that unless Carolina Optometry Associates, P.A. and my insurer have a prior agreement, I am personally responsible for all non-covered services, co-pays and deductibles.
- I authorize the release of medical information to insurance carrier or other physicians if it is deemed necessary by my optometrist for financial or consultative purposes.

Payment Policy: Payment in full is expected at the time professional services are rendered. We are happy to file for insurance payment when applicable. A charge of 1.5% per month will be added to all accounts 30 days past due. Failure to pay beyond a reasonable and allotted time may result in legal action, processing fees, collection agencies, and finance charges.

HIPAA CONSENT AND RIGHTS OF THE PATIENT

Carolina Optometry Associates, P.A. is authorized to release my information to the individuals listed above. I understand I have the right to revoke this authorization at any time by sending a written notification. I understand that a revocation is not effective in cases where the information has already been disclosed, but will be effective going forward. I understand the insurance notice above and agree to its terms.

Our privacy statement represents the policies of Dr. Andrew Graves, Dr. Melissa Graves, all associates doctors, and the entire staff of Carolina Optometry Associates, P.A.

I acknowledge that I received a copy of the privacy statement for Carolina Optometry Associates, P.A. *(Copy of HIPAA statement is available upon request)*

Signature of Patient or Parent/Guardian:_____ **Date**: _____

Describe your reason for today's visit. (EXAMPLE: *blurry vision, contact lenses, routine eye exam, eye issue*)

Do you wear Glasses? ❑ YES ❑ NO Do you wear contact lenses? ❑ YES ❑ NO Would you like to try Contacts? ❑ YES ❑ NO

Brand of contacts_____ How often are they replaced?_____(day(s)/weeks/months) Do you sleep in them? ❑ YES ❑ NO

Please list **ALL MEDICATIONS** *(including eye drops)*: ❑ NO MEDICATIONS

Do you have **ANY KNOWN ALLERGIES TO MEDICATIONS**? ❑ YES ❑ NO (IF YES, PLEASE LIST)

Do you have **ANY EYE CONDITIONS**? ❑ NONE (IF YES, PLEASE CHECK THE BOX THAT APPLIES)

❑ Glaucoma ❑ Cataracts ❑ Macular Degeneration ❑ Blindness ❑ Lazy eye/Eye turn ❑ Retinal detachment
❑ Other:

Social History

Tobacco ❑ YES ❑ NO Pk/Day_____ Alcohol ❑ YES ❑ NO

Do you ***currently*** have any problems in the following areas? (IF YES, PLEASE PROVIDE EXPLANATION)

MEDICAL AND OCULAR HISTORY	YES	NO	EXPLANATION OF PROBLEM
CONSTITUTION/GENERAL (cancer, fatigue, etc.)			
EAR, NOSE, THROAT (sinusitis, hearing, etc.)			
NEUROLOGICAL (migraines, epilepsy, etc.)			
PSYCHIATRIC (anxiety, depression, etc.)			
CARDIOVASCULAR (high blood pressure, etc.)			
RESPIRATORY (asthma, emphysema, etc.)			
GASTROINTESTINAL (stomach or intestines)			
GENITAL, KIDNEY, BLADDER			
MUSCLES, BONES, JOINTS			
SKIN (skin cancer, eczema, rosacea, etc.)			
ENDOCRINE (diabetes, hypothyroid, etc.)			
ALLERGIES (seasonal, etc)			

Family Medical and Ocular History: ❑ UNKNOWN FOR ALL IMMEDIATE FAMILY MEMBERS

YES	NO	CONDITION	RELATIONSHIP (CIRCLE)					
		CANCER	Father	Mother	Brother	Sister	Son	Daughter
		DIABETES	Father	Mother	Brother	Sister	Son	Daughter
		HIGH BLOOD PRESSURE	Father	Mother	Brother	Sister	Son	Daughter
		HYPERTHYROID	Father	Mother	Brother	Sister	Son	Daughter
		HYPOTHYROID	Father	Mother	Brother	Sister	Son	Daughter
		CATARACTS	Father	Mother	Brother	Sister	Son	Daughter
		MACULAR DEGENERATION	Father	Mother	Brother	Sister	Son	Daughter
		GLAUCOMA	Father	Mother	Brother	Sister	Son	Daughter