

OSWEGO VISION, LTD.
Serving Your Eye Care Needs Since 1987

PATIENT HISTORY AND CONSENT FORM

How did you learn about our office? <input type="checkbox"/> Previous Patient <input type="checkbox"/> Convenient Location <input type="checkbox"/> Mailing <input type="checkbox"/> Newspaper					
<input type="checkbox"/> Yellow Pages		<input type="checkbox"/> Insurance		<input type="checkbox"/> Staff Member(Name)_____	
				<input type="checkbox"/> Friend/Family(Name)_____	

Responsible Party (if minor) _____

Patient's Last Name _____ **First Name** _____

Address _____ City _____ State _____ Zip _____

Patient's Date of Birth ____/____/____ Age _____ Social Security# ____/____/____

Home Phone _____ Cell Phone _____ Work Phone _____

Occupation _____ Employer _____ E-mail _____

Your Insurance Information:		
Medical Insurance _____	Vision Insurance _____	
Insured Name _____	Date of Birth ____/____/____	Social Security # ____/____/____
A medical insurance card must be presented at time of service.		

Your Health Information:

Primary care physician's name _____ City _____

List of medications _____

Medical History (check all that apply)	Patient	Family	I Currently Wear:
High blood pressure	___	___	___ Glasses
Diabetes	___	___	___ Distance only
Heart problems	___	___	___ Reading Only
Lung problems	___	___	___ Lined bifocal
Thyroid problems	___	___	___ Trifocal
Medical allergy	___	___	___ No line bifocal
Seasonal allergy	___	___	___ Contact lenses
Other _____	___	___	___ Daily wear
Eye History (check all that apply)			___ Extended wear
Injury	___	___	___ Soft
Surgery	___	___	___ Soft toric
Cataracts	___	___	___ Hard
Glaucoma	___	___	___ Gas permeable
Lazy eye	___	___	___ Bifocal
Retina problems	___	___	___ Monovision
Macular degeneration	___	___	___ I replace my contacts every _____
Other _____	___	___	___ Contact lens solution _____

Release of Information: You may release any/and all information to the following family members:
Name/Relationship): _____

Insurance Verification You are **financially responsible** for all services, product charges, should your insurance consider any of these charges to be non-covered expenses. **Insurance** is not a guarantee of payment. Any and all refunds are processed at the end of each month. **Insurance coverage** is the patient's responsibility. For any services other than routine eye coverage, we will bill your insurance company. If for any reason the claim is denied, you are responsible for payment in full. **Insurance must be presented at time of service. We will no longer be able to process any insurance and/or discounts at a later date.**

Responsibility Statement/Acknowledgment of Privacy Practices This form permits our office to computer generate, electronically file and/or personally file any and all claims pertaining to any visual insurance claim. I, the patient, and/or responsible party, give permission to Oswego Vision, Ltd., to release any information necessary to file for my insurance. I am fully aware that neither confidential information, nor any other information not routinely needed to filing my insurance will be released.

I acknowledge and have been made aware that, **Oswego Vision, Ltd.** has a **Notice of Privacy Practices**, a copy which has been offered for inspection.

Signature _____ Date _____

Relationship to patient _____