Patient Information and Consent *Oswego Vision, Ltd.*

Patient's Last Name_____ **First Name**_____
Responsible Party (if minor)_____
Address_____ City_____ State_____ Zip_____
Home Phone_____ **Cell Phone**_____ **Work Phone**_____
Patient's Date of Birth ____/____/____ **Age** _____ **Social Security#** ____/____/_____
Male___ **Female**___ **Marital Status**: Single____ Married_____ Divorced _____ Widowed_____

Required: Race: _____ Language:_____
Ethnicity: Not Hispanic_____ Hispanic_____ Native Hawaiian/Other Pacific Island_____

Occupation_____ **Employer**_____ **E-Mail**_____
By providing your e-mail address you are giving Oswego Vision, Ltd. permission to send you e-mail notifications*
COMMUNICATION PREFERENCE: PHONE _____ POSTAL_____ E-MAIL_____

Insurance Information: **A medical insurance card must be presented at time of service**
Medical Insurance_____ Vision Insurance_____
Insured Name_____Date of Birth____/___/___Social Security # ____/___/____
WE WILL NO LONGER BE ABLE TO PROCESS ANY INSURANCE AND/OR DISCOUNTS AT A LATER DATE THAN THE ACTUAL DATE OF SERVICE

Your Health Information:
Do You Smoke? _____Yes ____ No _____ Occasionally
Primary care physican's name_____City_____

List of medications_____

Are you allergic to any medications? If yes, Please list._____

Medical History (check all that apply)	**Patient**	**Family**
High blood pressure	___	___
Diabetes	___	___
Heart problems	___	___
Lung problems	___	___
Thyroid problems	___	___
Medical allergy	___	___
Seasonal allergy	___	___
Other_____	___	___
Eye History (check all that apply)		
Injury	___	___
Surgery	___	___
Cataracts	___	___
Glaucoma	___	___
Lazy eye	___	___
Retina problems	___	___
Macular degeneration	___	___

I Currently Wear:
_____ Glasses
_____ Distance only
_____ Reading Only
_____ Lined bifocal
_____ Trifocal
_____ No line bifocal
_____ Contact lenses (Replaced Every _____)
_____ Daily wear
_____ Extended wear
_____ Soft
_____ Soft toric
_____ Hard
_____ Gas permeable
_____ Bifocal
_____ Monovision
Contact Solution Used: _____

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

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

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 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_____

OSWEGOVISION

SINCE 1987

INSURANCE INFORMATION

Medical Insurance Name_____ PPO or HMO _____

Medical Insurance ID Number _____ Group Number _____

Vision Insurance Name _____

Vision Insurance ID Number or Policy Holder SS# _____

Subscriber's Name_____ Date of Birth_____/____/____

Social Security # _____/____/_____

Subscriber's Relationship to Patient _____

WE WILL NOT PROCESS ANY INSURANCE AND/OR DISCOUNTS AT A LATER DATE OTHER THAN THE ACTUAL DATE OF SERVICE. PATIENT IS RESPONSIBLE TO PROVIDE COMPLETE AND ACCURATE INFORMATION AT THE TIME OF APPOINTMENT. ALL FEES FOR SERVICES RENDERED ARE DUE AT TIME OF SERVICE.

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PATIENT SIGNATURE _____ **DATE** _____

Revised 8/27/2020