WELCOME TO DILWORTH EYE ASSOCIATES

PATIENT INFORMATION	INSURANCE INFORMATION
NAME:	VISION INSURANCE
DATE OF BIRTH:	MEDICAL INSURANCE:
ADDRESS:	INSURED NAME:
CITY/STATE ZIP:	INSURED SSN:
HOME PHONE:	INSURED DOB:
CELL PHONE:	RELATIONSHIP TO INSURED:
	OCCUPATION:

MEDICAL HISTORY

NAME OF FAMILY PHYSICIAN _____
LIST CURRENT MEDICATIONS _____
_____
_____
LIST MEDICAL ALLERGIES _____

HAVE **YOU** EVER BEEN DIAGNOSED WITH:

DIABETES _____
HIGH BLOOD PRESSURE_____
CHOLESTEROL _____
CANCER _____
HIV/AIDS _____
THYROID _____
INFECTIOUS DISEASE _____
RETINAL DISEASE _____
GLAUCOMA _____

ARE YOU PREGNANT/BREASTFEEDING
YES / NO
IS THERE ANY FAMILY HISTORY OF ANY DISEASE
_____
_____
_____

PLEASE BE AWARE THAT VISION INSURANCE WILL NOT COVER A MEDICAL EYE PROBLEM. VISION INSURANCE WILL ONLY COVER EXAMS FOR ROUTINE VISION/GLASSES/CONTACTS. ALL OTHER EYE CONDITIONS ARE FILED THROUGH YOUR MEDICAL INSURANCE _____**INITIAL**

WE ARE REQUIRED BY LAW TO PROVIDE YOU WITH OUR HIPPA NOTICE OF PRIVACY POLICIES WHICH EXPLAINS HOW WE USE AND DISCLOSE YOUR HEALTH INFORMATION. WE ARE REQUIRED TO OBTAIN YOUR SIGNATURE THAT THIS NOTICE HAS BEEN MADE AVAILABLE TO YOU. _____**SIGNATURE**

I HEREBY GIVE AUTHORIZATION FOR PAYMENT OF INSURANCE BENEFITS MADE TO DILWORTH EYE ASSOCIATES FOR SERVICES RENDERD. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WETHER OR NOT THEY ARE COVERED BY INSURANCE. IN THE EVENT OF DEFAULT, I AGREE TO PAY ALL COSTS OF COLLECTION AND ATTORNEYS FEES INCURRED BY DILWORTH EYE ASSOCIATES. ALL SERVICES RENDERED ARE NON-REFUNDABLE.
_____**SIGNATURE**_____**DATE**

ALEX BUNICH OD