Welcome to Prather Family Eyecare

Todays Date:_____/_____/_____

Patient Name:_____ **DOB:**___/___/___ **Primary Phone Number:** (___) ___-____

Home Address:_____**City,State,Zip**:_____

Email:_____ **Occupation/Employer:**_____

How did you find Prather Family Eyecare?_____

Insurance Information

Who is the main holder of insurance? (Circle one of the following) Self / Spouse / Parent or Guardian

***If you circle anything other than " Self " please fill out the information below.**

Name:_____ **DOB:**___/___/____ **Social Security Number:** ____-___-____

Visual History

Reason for today's visit:_____

Date of last exam:___/___/___ **Location/Doctor**:_____

Do you use a computer/cell phone daily? Yes or No If "Yes" how many hours a day?_____

What type of protection do you currently use against harmful UV and Blue Light?_____

What are your hobbies/activities outside of work or school?_____

Current Contact Lens Wearers

How often do you *remove* your contacts? Daily / Other *If other please specify_____

How often do you *change* your contacts? Daily / Bi-Weekly /Monthly/Other_____

What type/brand of Contacts do you currently wear?_____

Personal and Family Health History

Primary care physician:_____ **Pharmacy:**_____

Type 1 or 2 Diabetic: Yes or No Self/ Please specify family member(s)_____

Hypertension: Yes or No Self/ Please specify family member(s)_____

Thyroid Disease: Yes or No Self/ Please specify family member(s)_____

History of stroke: Yes or No Self/ Please specify family member(s)_____

Auto immune/Genetic Disease: Yes or No Self/ Please specify family member(s)_____

Cataracts: Yes or No Self/ Please specify family member(s)_____

Glaucoma: Yes or No Self/ Please specify family member(s)_____

Macular Degeneration: Yes or No Self/ Please specify family member(s)_____

Please note any past eye injuries, surgeries, or diseases?_____

Current Medication(s)/Eye drops:_____

Allergies:_____

Release of Information

I authorize the release of any medical information necessary to my insurance company relative to services rendered. I further authorize the payment of Benefits to the Physician for services rendered. I understand that this authorization remains valid unless/until I revoke it myself.
Signature:_____ Date:_____

Financial Responsibility Statement

I acknowledge responsibility for payment of all medical fees regardless of insurance I may have to assist me in this responsibility. The only exception will be charges for services covered under a contractual agreement that has been entered into between my physician and insurance company, or other third party payer. If for any reason my account should become delinquent, I am liable to pay all collection and legal fees.
Signature:_____ Date:_____

Imaging Release

I consent that images, including photographs, may be taken in connection with the medical services I receive. I understand that such images shall be retained in my medical record and may need to be shared with others, including but not limited to my insurance carrier. I also give permission for these images and information relative to them and/or relating to my case to be published and republished for the purposes of medical research, education or science. I realize any publication of these images will be "de-identified" so they cannot be recognized as belonging to me specifically. I understand that this release remains valid unless/until I revoke it myself.
Signature:_____ Date:_____

I acknowledge that I received a copy of the Notice of Privacy Practices for Christopher R. Prather, Optometrist, P.C.
Signature:_____ Date:_____