Today's date: _____/_____/_____

Last Name: _____ First Name: _____ MI: _____

Home Address: _____ City: _____ Zip: _____

Date of Birth: _____/_____/_____ Male / Female / Other

Marital Status: Single / Married / Divorced / Widowed Spouse's Name: _____

If Minor, Responsible Party: _____ Relationship: _____

Are you employed? Yes / No Employer: _____ Occupation: _____

Employer's address: _____ City: _____ Zip: _____

Email Address: _____

Home Phone #: _____-_____-_____ Cell Phone #: _____-_____-_____

Work Phone #: _____-_____-_____ Ext.:_____

Primary Insurance: _____ Secondary Insurance: _____

Weight: _____ Height: _____ Smoke? Yes / No

If you have any of the following conditions, PLEASE CIRCLE:

HEART PROBLEMS
-Heart attack
-Angina
-Arrhythmia/ Pacemaker
-Congestive heart failure
-High blood pressure
STROKE
BLEEDING DISORDER

LUNG PROBLEMS
-Asthma
-Emphysema
-Bronchitis
-COPD
-Asbestosis
-Pneumonia

HEARING PROBLEMS
KIDNEY PROBLEMS
DIABETES Type 1 / Type 2
Current A1C: _____
Family History of Diabetes
Family History of Glaucoma

Referred by: _____
Personal Physician: _____ Phone #: _____-_____-_____
List of prior eye surgeries: _____
Any diagnosed eye diseases: _____
Current Medications: _____
Drug Allergies: _____
Do you currently wear prescription glasses or contact lenses? _____

Financial responsibility

I understand that I am financially responsible for all charges, whether or not paid by my insurance unless specifically exempted by my insurance company's contract with Hertzog Eye Associates.

I, _____ herby certify that I am eligible
Name of patient

For _____ benefits effective_____
Insurance Name Effective Date

I have chosen Hertzog Eye Associates to be my medical provider. I understand that if the above is not true, I am responsible for all charges related to the services provided to me. Also, if the above is not true, I agree to pay in full for all services received within 30 days of receiving a bill from Hertzog Eye Associates.

_____ _____
Signature of patient or responsible party Date

Permission to discuss personal health information with other individuals.

Instructions:
1. Write the name of all family members or other individuals who are involved in the patient's health care, and have the patient or the patient's personal representative sign and date the form.
2. If the patient's personal representative is signing the form on behalf of the patient, the personal representative must also sign and date the acknowledgment that he or she has the legal authority to do so.

Individuals to whom Hertzog Eye Associates may disclose my personal health information for coordination of care purposes.
I hereby grant Hertzog Eye Associates, its subsidiaries, and associated organizations permission to discuss my health information with the persons listed below as it relates to their involvement in the coordination of my care and payment for health care services I receive.

Name DOB Relationship to Patient Phone Number

1._____

2._____

3._____

_____ _____
Signature of patient or responsible party Date