WOLFEYECARE

Patient Information

DATE _____

Last _____
First _____ MI _____
Street _____
City _____
State _____ Zip Code _____
Home Phone _____
Cell Phone _____
Work Phone _____
Email _____
Date of Birth _____ Age _____
Sex ☐ M ☐ F

Single ____ Married ____ Divorced ____ Widowed ____

Patient's Last 4 Digits of SSN XXX-XX- __ __ __ __
Employer (Or School) _____
Spouse (Or Parent's Name) _____

What is the major purpose of this visit?

_____

Any problems with your current contact lenses or glasses?

Have you ever experienced, been diagnosed, or treated for any of the following?

☐ Blurry Vision
☐ Cataracts
☐ Crossed Eye/Eye Turn
☐ Eye Infections
☐ Flash of Light
☐ Glaucoma
☐ Headaches
☐ Itchiness
☐ Macular Degeneration
☐ Retinal Detachment
☐ Tearing
☐ Uncomfortable Glasses
☐ Other eye disorders or eye surgeries
☐ Burning
☐ Corneal Abrasions
☐ Double Vision
☐ Eye Injury
☐ Floaters/Spots
☐ Grittiness
☐ Iritis/Uveitis
☐ Lazy Eye
☐ Occasional Dryness
☐ Sunlight Sensetivity
☐ Trouble Seeing at Night

Insurance Information

Vision Insurance _____
Subscriber Name _____
Subscriber Last 4 Digits of SSN XXX-XX- __ __ __ __
Subscriber Birth Date _____

Primary Medical Insurance _____
Subscriber Name _____
Subscriber ID _____
Subscriber Birth Date _____

Do you participate in a flex spending account?
☐ Yes ☐ No

How will you settle your account today?
☐ Cash ☐ Check ☐ Credit Card

Medicare Release

I authorize benefits to be paid directly to RW Optometric CenterInc/dba, Dr. Robert Wolf. I understand that I am financially responsible for services and materials that Medicare does not cover. I authorize Dr. Robert Wolf or my insurance company(s) to release any information to process my claims. I authorize the release of any medical information necessary to process my claims and the release of information to my referring or primary care physician. Your signature will serve as your "signature on file" for processing Medicare claims.

Signature _____

HIPPA Privacy Practice acknowledgement: I have received or was offered and declined a notice of privacy practices

Signature _____ Date _____

What is your ethnicity? ☐ Hispanic/Latino ☐ Non Hispanic/Latino ☐ Unknown/Not Reported

What is your race? ☐ Native Hawaiian ☐ American Indian ☐ African American ☐ White ☐ Unknown/Not Reported

What is your preferred language?
☐ English ☐ Spanish ☐ Other

How did you hear about us? ☐ Website ☐ Friend