Patient Information **New Vision of Illinois, LLC.**

PLEASE NOTE: SOCIAL SECURITY NUMBER IS REQUIRED

INSURANCE INFORMATION **PLEASE BRING INSURANCE CARDS TO FRONT DESK**

Today's date:	**Primary Care Physician:**	Phone #:

Patient's Last Name:	**First:**	**Middle:**	Marital Status: (Circle One) Single / Married / Div. / Widow

Birth date:	Sex : M F	**Race: (required)**	**Language: (required)**	**Ethnicity: (Circle One) REQUIRED** Hispanic or Latino Not Hispanic or Latino

Street address:			
City:	State:	ZIP Code:	**Social Security # Required**

Email address:	HOME PHONE	CELL PHONE	WORK PHONE

Employer Name:	Employer Phone Number:
Spouse's Name:	Spouse's Date of Birth:
Spouse's Social Security Number	Spouse's Employer

Complete if Patient is covered under Parent's insurance or Legal Guardian

Parent or Legal Guardian Name:	**Social Security # Required**
Parent or Legal Guardian Birth date:	
Address (if different):	Phone #

Employer Name:	**Employer Phone #:**

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:		
	Home Phone#	Work Phone #	Cell Phone#

How did you hear about us? ❑ Insurance ❑ Radio ❑ TV Ad ❑ Internet/Website

❑Physician (Name):_____

❑ Friend/Relative (Name)_____

Patient Name_____**D.O.B.**_____

CONSENT TO TREAT

I hereby authorize the consent to the administration and performance of such medical treatments and diagnostic procedures as may be deemed necessary during the course of my appointment by my physician or his/her assistants. I understand that not following medical advice and treatment recommended by my doctor may cause or contribute to poor outcomes including loss of vision and/or loss of life. I have been advised that my examination may include dilation of the pupils, which may impair my ability to drive.

FINANCIAL ASSIGNMENT AGREEMENTS

I request that payment of authorized Medicare and/or insurance benefits be made on my behalf to New Vision of Illinois LLC. for any services furnished me by them. I authorize any holder of Medical information about me to release to the Health Care Financing Administration, its agents, or any other insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services. This assignment will remain in effect until revoked by me in writing.

I understand that I am financially responsible for all charges not covered by insurance. Unless I make prior arrangements, I will pay “out of pocket” charges at time of service. If I default and do not pay, New Vision of Illinois LLC. is entitled to the right of recovery of all collection expenses up to 50%, including all court costs and reasonable attorney’s fees incurred for the purpose of securing payment.

I am aware that my HMO Insurance requires a referral and/or prior approval for treatment and I am aware that if a referral/authorization is not present at the time of treatment, I am financially responsible for charges related to that visit.

Medical insurances (example: Medicare) do not pay for the examination required for glasses (refraction). I agree to be personally and fully responsible for payment.

I authorize New Vision of Illinois LLC. to communicate with me by phone, answering machine, letter, email at home or business regarding appointments, care or billing.

CONSENT TO USE AND DISCLOSURE OF HEALTH INFORMATION FOR THE TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

I consent to the use and disclosure of protected health information by New Vision of Illinois LLC. and their workforce for treatment, payment and healthcare operations purposes.

Patient/Parent Signature: _____Date:_____
(**Patient**, Parent (if patient is a minor child)/ Legal Guardian, or authorized party)

Printed name of Power of Attorney (if applicable)

_____

******NOTE****A copy of P.O.A. document must be provided at time of service.**

Name: _____

Date of Birth: _____

Primary Care Physician: _____

BRIGHTBILL/ERICSON EYE ASSOCIATES
NewVision
Laser Center • Eye Specialists • Optical

Do you wear correction? Please circle.

Prescription Glasses Readers RGP- Rigid Gas Permeable Contacts Soft Contact Lenses

How many years have you worn Contacts? _____ When did you last wear Contacts? _____

Please circle if you have or take medication for any of the following conditions:

Glaucoma	Macular Degeneration
High Blood Pressure	High Cholesterol
Heart Disease	Diabetes Mellitus: Type I Type II
Rheumatoid Arthritis	Sjogren's Syndrome
Lupus	Hepatitis
HIV/AIDS	Environmental/Seasonal Allergies
Thyroid Disease	Cancer; if yes, what type? _____
Multiple Sclerosis	Other: _____

Eye history/surgery: _____

_____

Do you smoke or use tobacco? Yes or No **Have you smoked or used tobacco in the past?** Yes or No

Has anyone in your family (Father, Mother, Sister, Brother) had any of the following? Please circle.

Glaucoma **F M S B** Macular Degeneration **F M S B** Diabetes **F M S B**

Please list any allergies to medications or medical products and your reaction.

_____

_____

_____

Please list any medications you take, including eye drops and vitamins/supplements.

(If you have a list, we can take a copy.)

_____

_____

_____

_____

More space available on back.

Name: _____

Date of Birth: _____

BRIGHTBILL/ERICSON EYE ASSOCIATES

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Medications continued: