Oasis Vision Center, P.C.

Patient Information Form

Patient Information (Please print clearly)

(circle) Mr. Mrs. Ms. Miss. Other: _____ Today's Date: ___/___/___

First Name: _____ MI: _____ Last: _____

Preferred Name: _____

Address: _____

City: _____ St: _____ Zip: _____

Date of Birth: ___/___/___ Social Security No: ___-___-___ Sex: ☐ M ☐ F

Employer Name: _____ Occupation: _____

Primary Phone: Work Home Cell (___) _____ Alternate Phone: Work Home Cell (___) _____

E-Mail: _____

How do you prefer to be contacted for appointment reminders, appointment confirmations and notification when orders are ready for pick up? ☐ Primary Phone ☐ E-Mail

Emergency Contact Name: _____

Emergency Contact Phone: (___) _____

Parent or Guardian Name if under 18: _____ Relationship to patient: _____

Insurance Information

Ins. Company Name: _____ Employer Name: _____

Member's Name: _____

Member's Date of Birth: ___/___/___ Member's Social Security or Insurance ID No: _____

Person Responsible For Charges Not Covered By Insurance

Name of Person Responsible for Payment: _____ Phone: (___) _____

Address: _____

City: _____ St: _____ Zip: _____

It is your responsibility to understand your insurance plan is a contract between you and your insurance company, but not with Oasis Vision Center, P.C. Our office cannot guarantee your insurance will pay, but we will make every attempt before providing you services to verify your policy benefits, if needed retrieve an insurance authorization, and share this information with you. On the condition that we are contracted as a provider with your insurance company we will submit your claim to your insurance company and allow 60 days for your insurance carrier to process and pay the claim. If for some reason your insurance company denies the claim, you are responsible for any amount due on your account immediately. By signing below I accept full financial responsibility.

Signature: _____ Date: ___/___/___

General Medical History

Do you have health conditions associated with the following?

☐ Heart	☐ GI / Stomach	☐ Respiratory	☐ Ears/Nose/Throat	☐ Mental
☐ Hypertension	☐ Genitourinary	☐ Thyroid	☐ Allergic/Immunologic	☐ Blood/Lymph
☐ High Cholesterol	☐ Musculosketal	☐ Diabetes	☐ Nervous system	☐ Skin

Please explain health conditions indicated above or list any other conditions you have: Do you currently smoke? ☐ Yes ☐ No

Have you had any surgeries? ☐ Y ☐ N List: _____ Date: _____

Name of Primary Care doctor: _____ Phone: (___) _____

Please complete the other side of this form

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Medications (Please print clearly)

Please list all over the counter and prescription medications you currently take:

Medication Name	Dosage	Reason for the medication

Name of the pharmacy you use: _____ Phone: ( ) _____

Please list any medication allergies: _____

Personal Eye Information

Have you had any eye injuries? □ Yes □ No List: _____

Have you had any eye surgeries? □ Yes □ No List: _____

Have you been diagnosed with any eye diseases or other eye problems? □ Yes □ No List: _____

Privacy Notice

Except as outlined in our Privacy Notice version 2013.05.17, our office will not release any of your information to anyone unless specifically authorized by you. You may authorize release of information to specific individuals by listing their names below.

Name: _____

Name: _____

I have received the Privacy Notice and Terms and Conditions Notice? □ Yes (please initial) _____

First Time At Oasis Vision Center

Are you a new patient to our office? □ Yes How did you find out about us? □ Insurance website □ Oasis website □ Personal referral

□ Oasis location □ Other: _____

If you were referred by someone please list their name so we may give them their referral reward: _____