Premier Eye Care Patient Information and Financial Agreement

652 Coleman Blvd., Suite 104
Mount Pleasant, SC 29464
843-849-2717

Personal Information

Name____ Date of Birth ____/____/____

Address____ City______________ ZIP_________

Home Phone (____)__________________________ Cell Phone (____)___________________________

Email Address _____________________________ Work Phone (____)__________________________

Employer__________________________________ Occupation _______________________________

Person Responsible for Insurance______________________________ Relationship ________________

Insurance Information

Vision Insurance ☐ None ☐ VSP ☐ AlwaysVision ☐ Humana ☐ EyeMed ☐ Spectera
☐ Superior Vision ☐ Davis Vision ☐ Other_________________

Medical Insurance ☐ None ☐ Aetna ☐ BlueCross/BlueShield ☐ BlueChoice ☐ Cigna
☐ Medicare ☐ United Health Care ☐ Other________________________

Patient's Social Security # _______/______/________

Insured's Social Security # _______/______/________

Medical Insurance Identification # __________________________ Group # ______________

Who may we thank for referring you to our office?

Name of friend or relative _________________________ Another Doctor ________________________

☐ Yellow Pages ☐ Insurance Listing ☐ Google ☐ Yelp ☐ Saw Sign/Building

☐ Other_____________________________

PAYMENT TERMS: We are happy to assist you in the filing of your insurance claim. If your insurance will not pay for the anticipated services and materials or your insurance pays you directly, we ask that you pay the balance. Office policy calls for payment of all doctor's fees at the time of service. If eyewear or contact lenses are to be ordered, a minimum of 50% deposit is required and the balance is due upon delivery. We accept cash, personal check, debit cards, flex spending account cards, VISA, Master Card, American Express and Discover. A 1.5% finance charge will be added to any accounts with an unpaid balance after 30 days, as allowed by South Carolina law. Patient agrees to pay all court cost, attorney's fees and other expenses if account is sent to collections.

Print Name ____

Signed ____ Date _________________________

For office use only: Patients ID#_________________________

Premier Eye Care Patient Medical History Form

General Health Information

Are you currently under a physician's care? ☐ Yes ☐ No Doctor's name ________________________

What medications do you take? ____

Are you allergic to any medications? ☐ Yes ☐ No Please List ___________________________

How would you describe your general health? (circle one) Excellent Good Fair Poor

Health History: Please check any body systems in which a condition exists with you or your immediate family and describe the condition.

	Self	Mother	Father	Siblings	Grandparents	Description
Allergy						
Cardiovascular						
Endocrine/Diabetes						
Genital/Urinary Tract						
Blood/Lymph						
Immune System						
Skin						
Muscle/Bones						
Neurological/Headaches						
Psychiatric						
Respiratory						
Cranial/Facial Trauma						
Gastrointestinal						

Ocular History: Please check any ocular conditions you or your immediate family

	Self	Mother	Father	Siblings	Grandparents	Description
Lazy Eye/Turned Eye						
Vision Therapy						
Color Blindness						
Cataracts						
Retinal Detachment						
Glaucoma						
Macular Degeneration						
Blindness						
Trauma/Surgery						

Social History: Please check all that apply

Do you use tobacco products? ☐ Yes ☐ No
Do you drink alcohol? ☐ Daily ☐ Weekly ☐ Occasionally ☐ Never
Do you recreationally use drugs? ☐ Yes ☐ No

This is your opportunity to tell us all about the areas in which your vision is not serving you well.

What is your main reason for coming today?____

Do you wear contacts at this time? ☐ Yes ☐ No What Brand? __________________________

Have you had any problems wearing contacts? ☐ Yes ☐ No Please describe________________________________

Have you been told you cannot wear contacts? ☐ Yes ☐ No Are you interested in trying contacts? ☐ Yes ☐ No