Welcome to Dearborn Eye Care

Patient Information

Date: ______________________

Name: ______________ ______________ → Preferred Name: ______________
First Name / Last Name

Address: ______________________

City: ______________________

State: __________ Zip code: __________

☐ Single ☐ Married ☐ Domestic Partner ☐ Divorced ☐ Widowed

Gender: ☐ Male ☐ Female

Birth date: ______________ Age: ________

Last 4 of SSN: ______________

Employer: ______________ ☐ Student

Occupation: ______________

For future recall & product ready notifications, please provide:

Cell phone: ______________________

E-mail: ______________________

Home phone: ______________________

Emergency contact: ______________________

Emergency phone #: ______________________

Financial & Insurance Information

Who is responsible for payment? ______________

Address: ______________________

City: ______________________

State: __________ Zip code: __________

Home phone: ______________________

Relationship to patient: ______________

Birth date: ______________

Insurance: ______________

Member #: ______________

Group #: ______________

Work phone: ______________

Eye Health History

Name of last eye doctor (if not here): ______________

Approximate date of last eye exam (if not here): __________

Have you had LASIK, PRK or RK? ☐ Yes ☐ No

Do you wear glasses? ☐ Yes ☐ No

Do you currently wear contacts? ☐ Yes ☐ No

- If no, are you interested in contacts? ☐ Yes ☐ No

Check the box if you have recently experienced or been diagnosed with any of the following **with** your glasses or contacts:

Bloodshot eyes	☐	Floaters or spots in vision	☐
Blurred vision – distance	☐	Glaucoma	☐
Blurred vision – near	☐	Migraine headaches	☐
Burning in eyes	☐	Headaches	☐
Cataracts	☐	Itching eyes	☐
Crossed eyes	☐	Light sensitivity	☐
Discharge from eyes	☐	Poor color vision	☐
Dizzy spells	☐	Poor night vision	☐
Double vision	☐	Red eyes	☐
Dry eyes	☐	Seeing flashes of light	☐
Eye infection	☐	Seeing halos	☐
Eye injury	☐	Temporary loss of vision	☐
Eye strain	☐	Twitching eyelid	☐
Fainting spells	☐	Watering eyes	☐

- Please turn over and complete other side -

Health History

Name of general practitioner or doctor: ______________________________

Check the appropriate box if you or any blood relatives have had any of the following medical conditions:

☐ Check here if adopted

	Yourself	Blood relatives		Yourself	Blood relatives
ADD or ADHD	☐	☐	Gastrointestinal condition	☐	☐
Hay fever	☐	☐	AIDS or HIV	☐	☐
Artificial heart valve	☐	☐	Hepatitis	☐	☐
Heart condition or Pacemaker	☐	☐	Kidney disease	☐	☐
High blood pressure	☐	☐	Currently pregnant	☐	
High cholesterol	☐	☐	Shingles	☐	☐
Stroke	☐	☐	Skin condition – type: ________	☐	☐
Cancer – type: ____________	☐	☐	Artificial joints	☐	☐
Diabetes	☐	☐	Rheumatoid arthritis or Lupus	☐	☐
Thyroid condition	☐	☐	Autism	☐	☐
Blindness	☐	☐	Epilepsy	☐	☐
Cataracts	☐	☐	Mental condition: ________	☐	☐
Retinal disease	☐	☐	Depression	☐	☐
Glaucoma	☐	☐	Asthma	☐	☐
Lazy eye or amblyopia	☐	☐	Emphysema or COPD	☐	☐
Macular degeneration	☐	☐	Tuberculosis	☐	☐
Poor color vision	☐	☐	Chemical dependency	☐	☐
Eye injury / surgery – please list ⇘	☐	☐	Migraine headaches	☐	☐

Other pertinent health information: ______________________________

Do you smoke? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No

Medications

List any medications you currently take, including eye drops: ☐ None

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____

____

List any allergies to medications or other substances that you have: ☐ None

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Authorization, Financial Policy & HIPAA Statement

I authorize Dr. Tarraf to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such eye care to third party payers for the purpose of payment, and/or health practitioners until otherwise requested in writing. I assign all insurance benefits, if any, to Dr. Tarraf otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Dearborn Eye Care requires payment in full for examination fees, and at least 50% of lab orders at the time of service or ordering. We accept cash, Visa, Master Card, Discover, American Express, Apple Pay, and Google pay. Client(s) will be responsible for any balances owed. If balances are not paid, the client will be responsible for all collection agency fees and attorney fees totaling an additional 25% of the current account balance at the time the account is sent to collections.

By signing below, I agree to receive email messages from Dearborn Eye Care. I understand that I may withdraw my consent to receive email anytime by notifying Dearborn Eye Care in writing. By signing below, I agree to receive text messages from Dearborn Eye Care. I understand that I will be responsible for any fees that my mobile carrier charges receiving such messages, and I may withdraw my consent at any time by notifying Dearborn Eye care in writing.

"I have read the Dearborn Eye Care HIPAA Notice of Privacy Policy posted in the office waiting area."

"I have read the contents of this page and understand by signing my name, I agree to all of the terms and conditions."

Signature: ______________________________ Date: ______________________________