PATIENT INFORMATION SHEET

Date: _____

Dr. Mr. Mrs. Ms. _____

(First) (Last)

Birthday: _____ Social Security#: _____

List name of person responsible for account:

Name: _____ DOB: _____ Phone Number: _____

Medical History

Do you or any of your immediate relatives (grandparents/parents/siblings) have (or had) any of the following:

	Self	Relative		Self	Relative		Yes	No
Arthritis	☐	☐	Cataracts	☐	☐			
Asthma	☐	☐	Crossed/Lazy Eye	☐	☐	Do you see double?	☐	☐
Diabetes	☐	☐	Eye injury	☐	☐	Eyes ever been Dilated?	☐	☐
Heart Disease	☐	☐	Eye Surger	☐	☐	Frequent Headaches?	☐	☐
High Cholesterol	☐	☐	Glaucoma	☐	☐	Dry eyes?	☐	☐
Hypertension	☐	☐	Macular Degeneration	☐	☐	Are you Pregnant?	☐	☐
Thyroid Problems	☐	☐						

Medications you are taking (prescription or over the counter): _____

Allergies (include any medications): _____

Acknowledgement of Receipt

I acknowledge that I have been offered a copy of the Notice of Privacy Practices of

Eyecare Associates of Bethany
Dr. Mark Privott
7415 N.W. 23rd Street
Bethany, OK 73008

Patient Name: _____

Signature: _____ Date: _____

I authorize access to my medical information to:

Name: _____
Name: _____

Payment Policy

☐ I authorize Dr. Mark Privott to file my insurance and release any information about me to my insurance company and its agents necessary to determine benefits and payments.

☐ I understand I am responsible for any charges for services or materials that are incurred.

Signature: _____ Date: _____

Cowan Printing (405) 789-1961