Walden Eye Care: Health History Form

Address:	Date:	Name:	(First)	(MI)		(1 a a b)
Cell #	Address:		• •	· ·	State:	, ,
Prefered contact method: Text Call Email Employer:	DOB:	Soc. Sec #:		_ Sex: M□ F□	Do you have	a HSA/FSA? [Y] [N]
Employer:	Cell #	Land #		Email:		
Primary Medical DoctorName/Location/Phone#: Preferred Pharmacy Name/Location: Do you wear glasses: [M][N] Readers: [M][N] Do you wear contacts: [M][N] Wearing contacts today [M] [N] Check if you've been diagnosed with any of the following conditions: Cancer: [Type	Prefered contact meth	od: Text Ca	all Email _			
Preferred Pharmacy Name/Location: Do you wear glasses: [M][N] Readers: [M][N] Do you wear contacts: [M][N] Wearing contacts today [M] [N] Check if you've been diagnosed with any of the following conditions: Cancer: Type	Employer:					
Do you wear glasses: [Y][N] Readers: [Y][N] Do you wear contacts: [Y][N] Wearing contacts today [Y] [N]	Primary Medical Docto	rName/Locatio	on/Phone#:	70		
Check if you've been diagnosed with any of the following conditions: Cancer: Type	Preferred Pharmacy Na	ame/Location:				
Check if you've been diagnosed with any of the following conditions: Cancer: Type	Do you wear glasses: [Y]	[N] Readers: [Y][N] Do you v	wear contacts: [Y	[N] Wearing co	ontacts today [Y] [N]
Cancer: Type						
Migraines: Diabetic: Type Macular Degeneration: High Blood Pressure: Thyroid Problems: Retinal Disease: High Cholesterol: Retinal Disease: High Cholesterol: Retinal Detachment: Respiratory Problems: Hepatitis: Type Blindness: Rt Eye Lt Eye Currently Pregnant: [M] [N] HIV/AIDS: Currently Nursing: [M] [N] Glaucoma: Currently Nursing: [M] [N] Glaucoma: Latex Sensitivity [M] [N] Cher condition(s) not listed: Latex Sensitivity [M] [N] Current Medications: Pt provided a list Latex Sensitivity [M] [N] Medication Allergies	_	-		-		tes
High Blood Pressure: Thyroid Problems: Retinal Disease: Retinal Disease: Respiratory Problems: High Cholesterol: Retinal Detachment: Blindness: Rt Eye Lt Eye Currently Pregnant: M [N] HIV/AIDS: Blindness: Rt Eye Lt Eye Currently Nursing: M [N] Glaucoma: Currently Nursing: M [N] Glaucoma: Latex Sensitivity M [N] Current Medications: Pt provided a list Latex Sensitivity M [N] Latex Sensitivity M [N] Medication Allergies Other Allergi	- ·		-			•
High Cholesterol: Retinal Detachment: Respiratory Problems: Hepatitis: Type					_	
Respiratory Problems:	_	<u>-</u>			Retinal Detachn	nent: □
Currently Pregnant: [M] [N]		_			Blindness: □ R	t Eve □ Lt Eve □
Current Nursing: M [N] Glaucoma: Current Medications: Pt provided a list Medication Allergies Other Allergies Other Allergies Authorization to Discuss Your Information and Guarantee of Payment To comply with new HIPAA Federal Privacy Regulations, we must receive your written approval to discuss your case with anyone else including family, children, caregivers, etc. By authorizing this, we will be able to, without requiring your presence, discuss your case, answer any question and leave detailed messages and contact, in case of emergency, the person listed below. If you would like us to answer questions or discuss your case with anyone other than yourself, you must include them below. This authorization is optional and can be withdrawn at any time. Name: Relationship: Birthdate: Phone: Phone: Phone: Phone: Phone: Phone: Phone: Is authorize Dr. Walden to release any information including the diagnosis and the records of any treatment rendered to me or my child during the period of such eye care to third party payers, health practitioners, and/or employers until requested in writing 1 assign all insurance benefits, if any, to Walden Eye Care, LLC or services rendered. I understand that a financially responsible for all charges whether or not paid by insurance. I understand that insurance is not a guarantee of payment to Walden Eye Care, LLC discover, and amex. An overdraft fee of \$25 will be assessed for all returned checks. Contact lens exams will be subject to a contact lens fitting fee or a refitting fee each year. This document is valid until revoked in writing by the patient or a representative. I have read the contents of this page and understand by signing my name, I agree to all the terms and conditions contained in this document. I agree that I am financially responsible for what my insurance does not pay Welden Eye Care, LLC Lunderstand that it is my responsibility to understand my insurance. I have read the Walden Eye Care, LLC Bates and understand that it is my responsibility to understand						J J
Authorization to Discuss Your Information and Guarantee of Payment To comply with new HIPAA Federal Privacy Regulations, we must receive your written approval to discuss your case with anyone else including family, children, caregivers, etc. By authorizing this, we will be able to, without requiring your presence, discuss your case, answer any question and leave detailed messages and contact, in case of emergency, the person listed below. If you would like us to answer questions or discuss your case with anyone other than yourself, you must include them below. This authorization is optional and can be withdrawn at any time. Relationship: Phone: Phone: Birthdate: Phone: Phone: Phone: Phone: Phone: I authorize Dr. Walden to release any information including the diagnosis and the records of any treatment rendered to me or my child during the period of such eye care to third party payers, health practitioners, and/or employers until requested in writing, I assign all insurance benefits, if any, to Walden type Care, LLC or services rendered. I understand that I am financially responsible for all charges whether or or paid by insurance. I understand that it he exam and materials must be paid for in full at the time of payment to Walden Eye Care, LLC i understand that the exam and materials must be paid for in full at the time of service. We accept case, check, visa, mastercard, discover, and amex. An overdraft fee of \$25 will be assessed for all returned checks. Contact lens exams will be subject to a contact lens fitting fee or a refitting fee each year. This document is valid until revoked in writing by the patient or a representative. I have read the contents of this page and understand by signing my name, I agree to all the terms and conditions contained in this document i agree that I am financially responsible for what my insurance does not pay Walden Eye Care, LLC I understand that it is my responsibility to understand my insurance. I have read the Walden Eye Care, LLC Hove the Walden Eye Care, LLC		•				
Authorization to Discuss Your Information and Guarantee of Payment To comply with new HIPAA Federal Privacy Regulations, we must receive your written approval to discuss your case with anyone else including family, children, caregivers, etc. By authorizing this, we will be able to, without requiring your gresence, discuss your case, answer any question and leave detailed messages and contact, in case of emergency, the person listed below. If you would like us to answer questions or discuss your case with anyone other than yourself, you must include them below. This authorization is optional and can be withdrawn at any time. Name:					Latex Sensitivity	y [Y] [N]
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must include them below. This authorization is optional and can be withdrawn at any time. Relationship:					witton approval to	discuss vour case with
Birthdate: Phone:	anyone else including fam presence, discuss your case person listed below. If you must include them below. T	nily, children, care e, answer any qu would like us to This authorization	egivers, etc. By a estion and leave answer question is optional and ca	uthorizing this, we detailed messages s or discuss your can be withdrawn at	will be able to, and contact, in a case with anyone case with anyone cany time.	without requiring your case of emergency, the other than yourself, you
I authorize Dr. Walden to release any information including the diagnosis and the records of any treatment rendered to me or my child during the period of such eye care to third party payers, health practitioners, and/or employers until requested in writing. I assign all insurance benefits, if any, to Walden Eye Care, LLC for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that insurance is not a guarantee of payment to Walden Eye Care, LLC. I understand that the exam and materials must be paid for in full at the time of service. We accept cash, check, visa, mastercard, discover, and amex. An overdraft fee of \$25 will be assessed for all returned checks. Contact lens exams will be subject to a contact lens fitting fee or a refitting fee each year. This document is valid until revoked in writing by the patient or a representative. I have read the contents of this page and understand by signing my name, I agree to all the terms and conditions contained in this document. I agree that I am financially responsible for what my insurance does not pay Walden Eye Care, LLC. I understand that it is my responsibility to understand my insurance. I have read the Walden Eye Care, LLC HIPAA Notice of Privacy Policy provided. Signature: Date:						
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Signature: Date:	contained in this document Care, LLC. I understand tha	t. I agree that I an It it is my responsi	n financially resni	ansible for what my	rinsurance does n	ot pav Walden Eve
	Signature:			Date:		

<u>Immediate family members who also see Dr. Walden</u>

First and Last name:	Relations	hip to you:				
				·-		

NSURANCE INFORMA	TION *D	loace com	plete so we c	an verify	accuracy	
	ATION P	lease con	ipiete so we c	an veniy	accuracy	
Primary Vision: Policy Holde	r: ∩Self	□Spouse		Moth	ner	
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