Nethery Eye Associates

Patient Update

Patient Name ____ DOB ___________________________

Address ____ City ___________________ Zip _____________

Phone ______________________ Alt Phone ____________________ Email __________________________

Primary Insurance ___________________________ Secondary Insurance ____________________________

Medical Conditions ____

____

Surgeries ____

Medications ____

____

Allergies ____

Pharmacy _____________________________ Street ____________________________ Zip ____________

Emergency Contact ___________________________ Phone ____________ Relationship ______________

Primary Care Physician _______________________________ Optometrist ____________________________

Smoke? ____Yes ____No Packs per day ________ Quit? _____Yes When? ______________________

Drink Alcohol? _____Yes _____No How often? ____

Ethnicity: _____Hispanic or Latino ____Not Hispanic or Latino ____Unknown ____Decline to Specify

Race: _____American Indian or Alaska Native ____Asian ____Black or African American

____Native Hawaiian or Other Pacific Islander ____White ____Other ____Decline to Specify

I hereby authorize my doctor to release to the Social Security Administration or other insurance carriers any medical or other information needed for all services that I receive. I request that all insurance payments be made directly to my doctor. I understand if my insurance does not pay within 45 days or decides the service is "non-covered" that a bill will be sent directly to me. I further understand that I am responsible for any deductibles, co-insurance, and refraction fees at the time of service.

Signature ____ Date __________________________

I also understand that, if at any time, I change my insurance coverage to a managed care plan (i.e. Secure Horizons, Pacificare, or any other comparable plan) or change my primary physician, I am responsible for notifying your office of such change. If I fail to obtain a valid referral prior to my visit and I decide to be seen by Nethery Eye Associates, I understand that my services will be considered out of network and I will be solely responsible for the fees incurred.

Signature ____ Date __________________________

Continued on Reverse Side

Notice of Privacy Practices - Review Acknowledgement

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

____

Signature of Patient or Personal Representative

____

Date

____

Name of Patient or Personal Representative (Please Print)

____

If not patient, please describe Personal Representative's authority

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Please list the names of the persons you authorize Nethery Eye Associates to communicate with regarding your medical care:

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Name   Relationship

____

Name   Relationship

____

Name   Relationship

____

Name   Relationship

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Name   Relationship