Temple vision-Dr. John K. Cooke

Date:____________________________

Name: ____DOB:_________________Age: _______________

Address:____City:___________State:______Zip____________

Cell Ph (_____)______-_______Home Ph (_____)______-_______ Work Ph (_____)______-____________

Preferred contact method: Cell____ Text___ Home ____Work___ Email____

Employer:_____________________________________ Occupation:_________________________________

SSN# ___________________ Sex: M _____ F _____ Email: _______________________________________

Married _____ Single _____ Divorced _____ Widowed _____

Last Eye Exam: __________________________________ By Whom: ______________________________

Reason For Exam: Glasses ____ Contacts ____ Eye Injury ____ Frame/Lenses____ Other ___________

Have you ever worn Contacts? Y ____ N ____ Last date worn: ______________ Type: ______________

Health Insurance_________________________________ Vision Insurance______________________________

Policy Holder's Name: ____ DOB: _________________________

Policy Holder's SSN: ______________________________

Who is your primary care physician and where are they located: _________________________________

Are you allergic to any medications?____

CURRENT MEDICATIONS BEING TAKEN: ____

Do you or your family have a history of:

	Self	Family		Self	Family
Allergies	________	_____	Cataract	________	_____
Asthma	________	_____	Double Vision	________	_____
Cancer	________	_____	Eye Pain	________	_____
Cholesterol	________	_____	Floaters	________	_____
Diabetes	________	_____	Glaucoma	________	_____
Heart Disease	________	_____	Macular Degeneration	________	_____
High Blood Pressure	________	_____	Other: Explain	________	_____
Respiratory Problems	________	_____	________________________		
Thyroid Disease	________	_____	Are you pregnant? Y/N	Nursing? Y/N	

Have you ever had an eye injury or eye surgery? ____

Temple Vision Requires you to have fundus photography or Dilation (No Charge). This gives the Doctor the ability to examine the health of your retina which can reveal conditions such as Diabetes, Hypertension, Glaucoma, and Macular Degeneration. Although most vision insurance companies do not cover Fundus Photos, this is the best option to make sure your eyes are healthy. The cost of the photos is $19.00.

I authorize the release of any medical information necessary for the procession of insurance claims. I understand that I will be responsible for any and all charges not covered by my insurance and associated collection fees. I also understand professional service fees are non refundable.

______________________________________ ______________________

Signature Date

Financial Responsibility/ Records Release Consent Agreement

I understand that I am financially responsible for any charges incurred that are not paid for or covered by myself or my insurance company. **I am also financially responsible for any expenses related to the collections of balances due to Temple Vision.** I authorize **Temple Vision** to release my information necessary to process my claim. Furthermore, **I Do/Do Not** authorize **Temple Vision** to release my records to any other physician or third party participating to my care.

Signature: ____ Date: ____________________

HIPAA PRIVACY
ACKNOWLEDGEMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I, __________________________________ [Please print full legal name here] (the "Patient" or "Patient's legal representative"), have been presented with the Notice of Privacy Policy of **Temple Vision** (the "provider"), and have been offered a copy of such policy to keep for my records.

_______ [please initial here] I hereby acknowledge that I have been provided with a copy of the Policy.

_______ [please initial here] I hereby refuse to acknowledge receipt of the Policy. I understand that even though I may refuse to sign this acknowledgment, **Temple Vision** may still provide treatment to me.

____
Signature of Patient Date

____

For Office Use Only

I, ________________________________[please print full legal name here,] acting as ______________________ [please print relationship to or official position with Provider] for Provider attempted to obtain the written acknowledgment of receipt of the Policy of Provider on ___________ [Please insert date attempt was made], but acknowledgment could not be obtained because:

______ [Please initial here] Patient or Patient's legal representative refused to sign.

______ [Please initial here] Patient or Patient's legal representative could not be communicated with sufficiently to obtain acknowledgment.

______ [Please initial here] Emergency circumstances prevented securing acknowledgment.

______ [Please initial here] Other (please specify) ____________________________________
____
____

____
Signature of Provider Representative Date