

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 _____	_____	_____			
Have you ever had an eye injury or eye surgery? _____			Are you pregnant? Y/N	Nursing? Y/N	

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