McNeel Eye Center WELCOME BACK FORM

***Patients, please fill this form out if it has been more than 2 years since your last visit.**

Today's date _____ Email Address _____

Name _____

Address _____ City _____

State ____ Zip _____ Cell Phone _____ Alt Ph#_____

Is it OK to text message for appointment reminder and eye wear pickup? YES / NO

Social Security No. _____ DOB _____

Insurance Carrier _____

*Please give the receptionist all insurance cards and insurance information. This will be scanned into your electronic file along with your photo ID.

Employer _____ Occupation _____

Have you stopped or started any medications since your last visit? If Yes, please list

_____

Diagnostic Information

Do you have a pair of back up glasses?	YES	NO
Do you work on a computer for long periods of time?	YES	NO
Would you benefit from thinner, lighter lenses?	YES	NO
Do you spend a lot of time outdoors?	YES	NO
Do you have difficulty driving at night with glare?	YES	NO
Do your contact lenses dry out easily?	YES	NO
Are you interested in laser vision correction?	YES	NO

Consent & Authorization to Release Information

I hereby authorize treatment and the release of any information, diagnostic tests or photographs acquired in the course of my treatment to my referring doctor or insurance company as necessary. I understand that I am financially responsible for services and materials provided to me at McNeel Eye Center. If there is a balance on your account that goes over 90 days without being paid, your account will go to collections. I understand that if I do not pay on the day of service and to be billed, a $25.00 convenience fee will be added to my account. Typing name below is an electronic signature.

X _____

Name & Signature Date