WAITE VISION

PATIENT INFORMATION

Name _____ Gender ☐ M ☐ F
LAST FIRST MIDDLE

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Birthdate _____ Social Security Number _____ Email _____

What Is The Best Way to Contact You Email Text Message Home Phone Business Phone

Patient's or Parent's Employer _____ Business Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse's Name _____ Employer _____ Business Phone _____

Emergency Contact _____ Phone Number _____

Optometrist _____ Primary Care Physician _____

Whom May We Thank for Referring You ☐ Optometrist Dr. _____ Friend/Family _____

Waite Vision Website Social Media Site _____ Other _____

INSURANCE INFORMATION

Primary Insurance Company _____ Phone Number _____

Address _____ Contract Number (ID#) _____

Subscriber's Name _____ Subscriber's Birthdate _____

Subscriber's Relationship to Patient ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Subscriber's Employer _____

Group Name _____ Group Number _____

Secondary Insurance Company _____ Phone Number _____

Address _____ Contract Number (ID#) _____

Subscriber's Name _____

Subscriber's Relationship to Patient ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Subscriber's Employer _____ Co-Payment Amount $ _____

Group Name _____ Group Number _____

WAITE VISION

MEDICAL HISTORY

Medications (Please list all medications you are currently taking)

Allergies

Medical Problems, Surgical History & Hospitalizations

General History

YES	NO		DETAILS	YES	NO		COMMENTS
☐	☐	Weakness, fatigue or chills		☐	☐	Abdominal Pain	
☐	☐	Issues with hearing		☐	☐	Joint pain	
☐	☐	Chest pain (heart pain, angina)		☐	☐	Rashes	
☐	☐	Shortness of breath		☐	☐	Recent Numbness	
☐	☐	Diabetes IDDM/Type II					

Family History (Has anyone in your family had any of the following?)

YES	NO		DETAILS	YES	NO		COMMENTS
☐	☐	Glaucoma		☐	☐	Other Eye Issues	
☐	☐	Cataracts		☐	☐	Diabetes IDDM/Type II	
☐	☐	Cornea Disease		☐	☐	Hypertension	
☐	☐	Macular Degeneration		☐	☐	Heart Disease	
☐	☐	Retinal Detachment		☐	☐	Other	

Ocular History (Have you ever been diagnosed with any of the following?)

YES	NO		DETAILS	YES	NO		COMMENTS
☐	☐	Cataracts		☐	☐	Cornea Disease	
☐	☐	Retina Disease		☐	☐	Glaucoma	
☐	☐	Lazy Eye		☐	☐	Eye Injury	
☐	☐	Herpes Simplex of the Eye		☐	☐	Other Eye Disorder	

Ocular Surgery

R	L		DATE	R	L		DATE
☐	☐	Cataract Surgery		☐	☐	Retina Surgery	
☐	☐	LASIK or PRK		☐	☐	Other Surgery	

Current Ocular Issues

YES	NO		COMMENTS	YES	NO		COMMENTS
☐	☐	Loss of Vision		☐	☐	Double Vision	
☐	☐	Blurred Vision		☐	☐	Dryness	
☐	☐	Fluctuating Vision		☐	☐	Eye Pain/Soreness	
☐	☐	Halos		☐	☐	Redness	
☐	☐	Glare/Light Sensitivity		☐	☐	Itching	
☐	☐	Loss of Side Vision		☐	☐	Foreign Body Sensation	

WAITE VISION

FINANCIAL POLICY

Waite Vision is dedicated to providing you the best possible care.
If you have any questions regarding our financial policy, please speak with a team member

PAYMENT IN FULL IS DUE AT THE TIME OF SERVICE unless a prior written agreement has been made. This includes any co-payments and deductibles.

Please remember your insurance policy is a contract between you and your insurance company. As a service to you, we are happy to file an insurance claim with the benefits assigned to Waite Vision. (You agree to have the insurance company send payment directly to Waite Vision.) If your insurance company does not pay the practice within a reasonable time period, we will need to look to you for payment. If payment is later received from your insurer and you have paid for the services in full, we will refund any overpayment to you

We have made prior arrangements with many insurance companies. However, not all plans cover all of our services. In the event your insurance plan determines a service to be not covered, you will be responsible for the complete charge. Payment will be due upon receipt of a statement from our office.

If you are insured by a plan that we do not have a prior arrangement with, we are happy to prepare and send the claim for you on an unassigned basis. The insurance company will send any payment directly to you. Therefore, the fees for your care are due at the time of service.

I have read and I understand Waite Vision's financial policy and I agree to the terms. I also understand and agree such terms may be amended by the practice from time to time.

I authorize Waite Vision or their designees to release financially identifiable information and treatment descriptions and information, either electronically, by facsimile, or in paper form to my insurance carrier or any related entities that require such information to be submitted.

I authorize my insurance company to pay the proceeds of any benefits directly to Aaron Waite, M.D. or Waite Vision, PLLC. A copy of this agreement and my signature may be used as an original for insurance purposes.

I acknowledge that I have been provided an opportunity to read and review Waite Vision's Privacy Policies.

Signature of Patient, Parent or Guardian

Date

Printed Name

Relationship to Patient

Submit