Legal Name_____ **Nickname**_____ **Sex: M F**
Last First Middle Initial
Date of Birth:_____ **Marital Status: Single Married Widow Child Other**_____
Circle one

Address:_____ **Primary Phone:**_____

_____ **Secondary Phone:**_____
City / State / Zip **I would like text to: Primary Secondary No Text**

EMAIL:_____ **Any Special Needs? Wheelchair Hearing Impaired Interpreter Other**

Primary Language Spoken:_____

Race: ___American Indian or Alaskan Native ___Asian ___Black or African American ___Caucasian
___Native Hawaiian or other Pacific Islander ___Other

Ethnicity: ___Hispanic or Latino ___NOT Hispanic or Latino ___Unknown

Patients
Mother's maiden name:_____ **Birth Place:**_____ **Declined to answer:**_____
Please initial if declined

Emergency Contact:_____ **Relationship to patient:**_____
Name and phone number

Employer/School:_____ **Occupation/Grade:**_____

Hobbies:_____

Is your vision making it difficult to enjoy your hobbies, work, or school?:_____

How did you hear about our office? Friend Family Internet Insurance Phonebook Other_____
Circle one

Insurance Information/Financial Responsibility

Person Responsible for Acct:_____ **Phone 1:**_____ **Phone 2:**_____
Address:_____

Vision Insurance

_____ **Primary Insured:**_____ **DOB:**_____
Insurance ID:_____ **Employer:**_____ **Last 4 of SSN:**_____
Group ID:_____ **Relationship to patient:**_____

Primary Medical

_____ **Primary Insured:**_____ **DOB:**_____
Insurance ID:_____ **Employer:**_____ **Last 4 of SSN:**_____
Group ID:_____ **Relationship to patient:**_____

Secondary Medical

_____ **Primary Insured:**_____ **DOB:**_____
Insurance ID:_____ **Employer:**_____ **Last 4 of SSN:**_____
Group ID:_____ **Relationship to patient:**_____

Payment Policy: Payment is expected when services are rendered or materials ordered. Quotes of insurance coverage or benefits are based on information from your insurance company and are not guaranteed by Monument Vision Clinic. We will gladly bill your insurance for you; however, all charges remain your responsibility until insurance has paid the balance. If payment has not been received from the insurance after 60 days of the billing date, the patient/responsible party will be expected to pay any remaining balance to Monument Vision Clinic.
By signing below, I acknowledge that I am personally responsible for payment of my account, even if I have insurance. My signature authorizes Monument Vision Clinic to bill my insurance company on my behalf. I agree that Monument Vision Clinic may release copies of my medical information to my insurance company in order to obtain payment from my insurance. If it becomes necessary to use a collection agency for any amount owed on this or subsequent visits, I agree to pay for all costs and expenses, including reasonable attorney's fees. I understand a fee of $50.00 will be charged to my account if it is assigned to a collection agency.

Sign:_____ **Date:**_____

Information Verified by & on: **Sign:**_____ **Date:**_____

Information Verified by & on **Sign:**_____ **Date:**_____

Information Verified by & on **Sign:**_____ **Date:**_____

PERSONAL HEALTH HISTORY

We respect our legal obligation to keep your health information private. We are obligated by law to inform you of our notice of privacy practices. If you would like to receive a copy of our notice of privacy practices, you may request one at any time from the receptionist. We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act and the state of Colorado.

"I understand and acknowledge that Monument Vision Clinic has a notice of privacy practices which is available for my review if I wish. I acknowledge that Monument Vision Clinic has offered a copy of said policy.

____I have received a copy of the privacy practices

____I do not wish to receive a copy of the privacy practices

Signed:_____ **Date:**_____ **Signed:**_____ **Date:**_____
Patient or Authorized Representative Patient or Authorized Representative

Signed:_____ **Date:**_____ **Signed:**_____ **Date:**_____
Patient or Authorized Representative Patient or Authorized Representative

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Please answer the following questions as completely as possible. Your answers help us provide the best care for you. If you have any questions or concerns, please let the doctor know.

Do you smoke? Yes No Quit. **How much:**

Do you use any type of recreational Drugs: Yes No. **Drug Used:**

Do You Drink Alcohol: Yes No **How much:**

Please List all medications you take-Name and Dosage-_____

_____

_____

Are you allergic to any medications:_____

What reaction do you have:_____

Have you ever been treated by a physician for any of the following? Please Circle any "yes" answer.

Constitutional: Unusual Weight Loss or Gain, Insomnia, Tire Easily, Fever, Chills, Weakness, Fatigue, Other

Eyes: Double Vision, Dry Eye, Glaucoma, Cataracts, Macular Degeneration, Retinal Detachment, Injury, Other

Ears, Nose, Mouth, Throat: Chronic Cold, Sore Throat, Sinus Problems, Chronic Ear Infections, Other

Cardiovascular: High Blood Pressure, High Cholesterol, Heart Disease, Heart Murmur, Heart Surgery, Other

Respiratory: Asthma, Shortness of Breath, COPD, Bronchitis, Pneumonia, Emphysema, Other

Gastrointestinal: Crohn's Disease, GERD, Reflux, Constipation, Diarrhea, Other

Genitourinary: Problems with: Kidney, Bladder, Prostate, Ovarian, Uterine, Other

Musculoskeletal: Arthritis, Joint pain, Back pain, Muscle pain, Muscular Dystrophy, Other

Integumentary (skin): Bruising, Dryness, Dermatitis, Eczema, Rash, Psoriasis, Other

Neurological: Seizures, Stroke, Epilepsy, TIA, Migraines, Vertigo, Paralysis, Multiple Sclerosis, Other

Psychiatric: Alzheimer's, Dementia, Memory Loss, Confusion, Depression, Mood Swings, Other

Endocrine: Diabetes-Type 1 or Type 2, Hypoglycemic, Hypo-Thyroid, Hyper-Thyroid, Adrenal Gland, Other

Hematologic/Lymphatic: Anemia, Hemophilia, Leukemia, Hemochromatosis, Enlarged Lymph nodes, Other

Allergic/Immunologic: AIDS or HIV, Lupus, Auto Immune Disease, Seasonal Allergies, Other

Cancer: Have you been diagnosed with any type of cancer? YES NO. (Please Explain if YES)

Surgery: Please list any surgeries you have had and approximate dates.