Lux Eye Care Studio

_____ _____ _____ _____

First Name Last Name Nickname Date of Birth

_____ _____

Street Address City State Zip SSN

_____ _____ _____ ☐Male ☐Female

Cell phone Home phone email

Vision Insurance Plan: Relationship to Insured:

_____ ☐Self ☐Spouse ☐Child ☐Other

_____ _____ _____ _____

Insured's First Name Insured's Last Name Date of Birth SS#

Medical Insurance Information:

Primary: _____

Secondary: _____

Name and Address of Insurance Co ID number Group #

Please Read: I acknowledge that I have had the chance to review the Notice of Privacy Practices and upon request may have a copy. The patient's portion is to be paid at the time service are rendered unless other arrangements are made. The undersigned will be responsible for any bill incurred in this office regardless of insurance. There will be a service charge of $25 on all returned checks. Professional services are not refundable, and all product sales are final. Any returns that are approved may be subject to a restocking fee. I authorize payment from my insurance to be paid directly to Lux Eye Care Studio. I understand that billing any out of network insurance will be my responsibility. I understand that all benefits quoted to me are not a guarantee of payment by my insurance and that final determination can only be made when the claim is processed. I authorize the use of this form on all insurance submissions and the release of all information to my insurance companies. I authorize the doctor to act as my agent in helping me obtain payment from my insurance. I permit a copy of this authorization to be used in place of the original.

Disclose Patient information to: _____

Patient/Guardian signature: _____

Primary Care Physician _____ Office phone/fax number_____

Please List all medications: _____

_____

Constitutional: ☐Fever ☐Weight loss/gain ☐Cancer ☐Other _____

Ear/Nose/Mouth: ☐Dry mouth/throat ☐Hearing loss ☐Sinusitis ☐Other _____

Neurological: ☐Seizures/epilepsy ☐Headaches ☐Migraines ☐Tumor ☐MS ☐Other _____

Psychiatric: ☐Anxiety/depression ☐Other _____

Vascular/Cardio: ☐Heart disease ☐High blood pressure ☐Stroke ☐Other _____

Respiratory: ☐Asthma ☐Sleep apnea ☐Emphysema ☐Chronic bronchitis ☐Other _____

Gastrointestinal: ☐Acid reflux ☐Chron's disease ☐Other _____

Genitourinary: ☐Pregnant ☐Nursing ☐Prostate disease ☐Other _____

Bones/Joints: ☐Rheumatoid Arthritis ☐Osteoporosis ☐Muscle/Joint Pain ☐Other _____

Integumentary: ☐Shingles/Herpes Zoster ☐Herpes Simplex ☐Rosacea ☐Other _____

Endocrine: ☐Type 1 diabetes ☐Type 2 diabetes ☐Thyroid disease ☐Other _____

Lymphatic/Hematologic: ☐High Cholesterol ☐Anemia ☐Other _____

Allergic/Immunologic: ☐Seasonal allergies ☐Sjogren's Syndrome ☐Lupus ☐Other _____

Have you or anyone in your immediate family been diagnosed with the following:

☐Cataract ☐Macular Degeneration ☐Glaucoma ☐Amblyopia ☐Retinal Detachment

Do you experience any of the following: ☐Loss of vision ☐Blurred vision ☐Flashes/floaters ☐Halos/Glare/light sensitivity ☐Eye injury ☐Dryness ☐Mucous Discharge ☐Tearing ☐Redness ☐Sandy/Gritty feeling ☐Itching ☐Burning ☐Foreign Body Sensation ☐Excess Tearing

Do you wear glasses? ☐Yes ☐No Are they for: ☐Full time ☐Reading/computer ☐Distance

Do you wear contact lenses? ☐Yes ☐No Brand of contacts _____