WAKE FOREST EYE CARE CENTER

To:	From:
_____	**Wake Forest Eye Care Center**
_____	**11724 Retail Dr.**
_____	**Wake Forest NC, 27587**
_____	**Phone: (919) 562-5559**
	Fax: (919) 562-5563

Records Release

Date: _____

Patient Name: _____

Date of Birth: _____

I hereby authorize my records, including any diagnosis and treatment, to be released to Wake Forest Eye Care Center located at 11724 Retail Dr. Wake Forest, NC 27587

Patient Signature: _____

Witness Signature: _____

Additional Notes: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

WAKE FOREST
EYE CARE CENTER

Welcome

Please Have your medical and vision insurance cards available; as well as, your glasses and contacts for your appointment.

Patient Demographics				
Last Name	First Name		MI	Nickname
Birth Date	Sex	Race	SSN	
Address	City, State, Zip			
Cell Phone	Home Phone		Email	
Marital Status	Occupation	Employer	Work Phone	
Insurance Subscriber:	Subscriber ID #:		Subscriber Birth Date:	
How did you hear about us?				
Primary Care Physcian Name and Phone number		Pharmacy with Address		

Medical History-Please Include Past and Current Conditions					
Ocular Problems	Self	Family (Relation)	**Psychiatric**	Self	Family (Relation)
Glaucoma			Depression		
Dry Eye			Anxiety		
Cataract			**Constitutional**	Self	Family (Relation)
Amblyopia (Lazy Eye)			Cancer (type?)		
Macular Degeneration			Developemental		
Inflammatory Disease			**Immunologic**	Self	Family (Relation)
Retinal Detachment			Rheumatoid Arthritis		
Strabismus (Eye Turn)			Lupus		
Neurological	Self	Family (Relation)	**Blood/ Lymph**	Self	Family (Relation)
Headaches			Anemia		
Cerebal Palsy			Blood Disease		
Multiple Sclerosis			**Genitourinary**	Self	Family (Relation)
Tumor			Prostate Disease/Cancer		
Epilepsy			STD's		
Cardivascular	Self	Family (Relation)	Kidney Disease		
Vascular Disease			**Gastrointestinal**	Self	Family (Relation)
Stroke			Colitis		
Congestive Heart Failure			Crohn's Disease		
Heart Disease			Ulcer		
High Blood Pressure			Irritable Bowel Syndrome		
High Cholesterol			**Other (Specify)**	Self	Family (Relation)
Endocrine	Self	Family (Relation)			
Diabetes-Type 1 or 2?					
Thyroid (Hypo/Hyper)					
Hormonal Dysfunction					

Medical Continued	
Please List any Medications including eye drops, over the counter medications, and any supplements you are taking:	
Please List any Allergies:	
Major Illness, Injury, or Surgery:	
Are you currently Pregnant or nursing?	
Do You Smoke?	Do you Drink Alcohol?

Current Eye Concerns					
	Yes	**No**		**Yes**	**No**
Blurred or Double Vision			Floaters		
Eye Injury			Diffculty in low light		
Flashes			Difficulty while driving		

Person Responsible for bill or Parent		
Complete (Only if different from patient being treated)		
Guarantor Name:	Social Security:	
Relationship to Patient (please Check): ( ) Self, ( ) Spouse, or ( ) Parent		Date of Birth:
Street Address:		
City:	State:	zip:

In Case Of Emergency Contact Information	
First Name:	Last Name:
Cell Phone:	Home Phone (optional):
Relationship to patient:	

Consent for treatment: I hereby authorize Wake Forest Eye Care Center to administer diagnostic and medical procedures as may be necessary. **Notice of Privacy Policy:** I hereby acknowledge I have recieved notice of my rights under HIPPA as it applies to my vist at Wake Forest Eye Care Center. **Insurance:** I hereby authorize Wake Forest Eye Care Center to file applicable insurance claims, including any release of any medical or other information necessary to process claims. I acknowledge that most insurance policies pay only a portion of total charges. Wake Forest Eye Care Center does not guarantee the accuracy of benefit information provided to us by insurance companies. Patient is responsible for any and all remaining balances not covered by insurance. Patients are responsible for all late penalties, and collections fees. **Patient Rights:** Wake Forest Eye Care Center Guarantees the right to itemized receipt(s), exam records, and current prescriptions upon request.

Signature: _____ Date: _____

WAKE FOREST
EYE CARE CENTER

Consent Form for Delivery of Prescription

Please select an Answer in each section:

I would like my eyeglasses and/or contact Lens prescription sent to me electronically via email (Must have an email on file):

- ☐ Yes
- ☐ No

I would like my eyeglasses and/or contact lens prescription given to me via paper form:

- ☐ Yes
- ☐ No

Please sign below to acknowledge that you were provided with an optional copy of your eyeglasses prescription after completing your annual eye exam.

Patient Printed Name:_____

Patient Signature: _____

Date:_____