

THOMAS DENTAL CARE
DIRK THOMAS, D.D.S.

PATIENT INFORMATION

PATIENT NAME: FIRST _____ MI _____ LAST _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

DOB _____ SSN _____ EMPLOYER _____

NAME OF PERSON COMPLETING THIS FORM (IF DIFFERENT FROM PATIENT) _____

RELATION TO PATIENT _____

INSURANCE POLICY HOLDER INFORMATION

INSURED'S NAME: FIRST _____ MI _____ LAST _____

DOB: _____ SSN _____ RELATION TO PATIENT _____

INSURANCE COMPANY _____ PHONE _____

DENTAL HEALTH INFORMATION

THANK YOU FOR PROVIDING US WITH IMPORTANT INFORMATION THAT WILL HELP US SERVE YOU BETTER.

	YES	NO								
ARE YOU HAVING ANY DISCOMFORT?	<input type="checkbox"/>	<input type="checkbox"/>								
ANY SENSITIVITY TO HOT, COLD, SWEETS, CHEWING?	<input type="checkbox"/>	<input type="checkbox"/>								
DOES DENTAL TREATMENT MAKE YOU NERVOUS?	<input type="checkbox"/>	<input type="checkbox"/>								
HAVE YOU EXPERIENCED ANY OF THE FOLLOWING PROBLEMS?										
BLEEDING GUMS	<input type="checkbox"/>	<input type="checkbox"/>								
BAD BREATH	<input type="checkbox"/>	<input type="checkbox"/>								
SORENESS IN JAW JOINT	<input type="checkbox"/>	<input type="checkbox"/>								
GRINDING OF TEETH	<input type="checkbox"/>	<input type="checkbox"/>								
SNORING	<input type="checkbox"/>	<input type="checkbox"/>								
ON A SCALE OF 1 TO 10 (WITH 10 BEING THE HIGHEST)										
HOW IMPORTANT IS YOUR DENTAL HEALTH TO YOU?	1	2	3	4	5	6	7	8	9	
10										
WHERE WOULD YOU RATE YOUR DENTAL HEALTH?	1	2	3	4	5	6	7	8	9	10
WHERE WOULD YOU LIKE YOUR DENTAL HEALTH TO BE?	1	2	3	4	5	6	7	8	9	10
DO YOU THINK YOUR DENTAL HEALTH AFFECTS YOUR OVERALL HEALTH?	<input type="checkbox"/>	<input type="checkbox"/>								
DO YOU THINK IT IS IMPORTANT TO HAVE YOUR TEETH CLEANED AT LEAST EVERY 6 MONTHS?	<input type="checkbox"/>	<input type="checkbox"/>								
IS THE BRIGHTNESS OF YOUR TEETH IMPORTANT TO YOU?	<input type="checkbox"/>	<input type="checkbox"/>								

DO YOU SMOKE OR USE TOBACCO IN ANY FORM? YES NO

DO YOU DRINK COFFEE OR TEA? YES NO

DENTAL HEALTH INFORMATION

	YES	NO
IF I COULD CHANGE MY SMILE, I WOULD MAKE MY TEETH:		
WHITER/BRIGHTER	<input type="checkbox"/>	<input type="checkbox"/>
STRAIGHTER	<input type="checkbox"/>	<input type="checkbox"/>
CLOSE SPACE	<input type="checkbox"/>	<input type="checkbox"/>
REPLACE BLACK MERCURY FILLINGS WITH TOOTH COLORED RESTORATIONS	<input type="checkbox"/>	
<input type="checkbox"/> REPAIR CHIPPED TEETH	<input type="checkbox"/>	<input type="checkbox"/>
REPLACE MISSING TEETH	<input type="checkbox"/>	<input type="checkbox"/>
LESS GUM SHOWING	<input type="checkbox"/>	
<input type="checkbox"/> REPLACE OLD CROWNS OR CAPS THAT DO NOT MATCH		
<input type="checkbox"/> _____		

DO YOU PREFER TO SAVE YOUR TEETH? YES NO

HAVE YOU EVER HAD A SPECIAL COATING APPLIED TO YOUR BACK TEETH
TO PROTECT FROM TOOTH DECAY? YES NO

DO YOU TAKE A FLOURIDE SUPPLEMENT? YES NO

WHEN WAS THE LAST TIME YOU HAD AN ORAL CANCER EXAM? _____

DATE OF LAST CLEANING? _____

IF THERE WERE A WAY TO WHITEN YOUR TEETH FOR A VERY REASONABLE
INVESTMENT, WOULD YOU BE INTERESTED? YES NO

WHAT IS THE MOST IMPORTANT THING TO YOU ABOUT YOUR FUTURE SMILE AND DENTAL HEALTH?

WHAT IS THE MOST IMPORTANT THING TO YOU ABOUT YOUR DENTAL VISIT TODAY?

GENERAL HEALTH INFORMATION

	YES	NO
ARE YOU IN GOOD HEALTH?	<input type="checkbox"/>	<input type="checkbox"/>

HAS THERE BEEN ANY CHANGE IN YOUR GENERAL HEALTH IN THE PAST YEAR? YES NO

DATE OF LAST CHECK-UP BY PHYSICIAN _____

ARE YOU CURRENTLY UNDER A PHYSICIANS' CARE? YES NO
IF SO, FOR WHAT? _____
PHYSICIANS NAME _____ PHONE _____

HAVE YOU HAD ANY SERIOUS ILLNESSES, OPERATIONS, OR HOSPITALIZATIONS? YES NO
IF SO, DESCRIBE AND GIVE APPROXIMATE DATES _____

HAVE YOU EVER HAD INTRAVENOUS SEDATION OR GENERAL ANESTHESIA?

DO YOU GENERALLY TOLERATE DENTAL TREATMENT WELL?

HOW OFTEN DO YOU BRUSH? _____ FLOSS? _____

GENERAL HEALTH INFORMATION

	YES	NO
DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING:		
HEART DISEASE DETECTED AT BIRTH?	<input type="checkbox"/>	<input type="checkbox"/>
RHEUMATIC FEVER OR RHEUMATIC HEART DISEASE?	<input type="checkbox"/>	<input type="checkbox"/>
CARDIOVASCULAR DISEASE (CHEST PAIN, HEART ATTACK, CORONARY ARTERY DISEASE, HIGH BLOOD PRESSURE, STROKE, PALPITATIONS, HEART SURGERY, ANGIOPLASTY, PACEMAKER)?	<input type="checkbox"/>	<input type="checkbox"/>
LUNG DISEASE (ASTHMA, EMPHYSEMA, CHRONIC COUGH, BRONCHITIS, PNEUMONIA, TB, SHORTNESS OF BREATH, SEVERE COUGH)?	<input type="checkbox"/>	<input type="checkbox"/>
NEUROLOGICAL DISORDERS (SEIZURE, EPILEPSY, FAINTING, DIZZINESS, NERVOUS DISORDER)?	<input type="checkbox"/>	<input type="checkbox"/>
BLOOD DISEASE (BLEEDING DISORDER, ANEMIA, BLOOD TRANSFUSION, DO YOU BRUISE EASILY)?	<input type="checkbox"/>	<input type="checkbox"/>
LIVER DISEASE (JAUNDICE, HEPATITIS)?	<input type="checkbox"/>	<input type="checkbox"/>
KIDNEY DISEASE?	<input type="checkbox"/>	<input type="checkbox"/>
DIABETES?	<input type="checkbox"/>	<input type="checkbox"/>
THYROID DISEASE (HYPOTHYROIDISM, TUMOR)?	<input type="checkbox"/>	<input type="checkbox"/>
ARTHRITIS?	<input type="checkbox"/>	<input type="checkbox"/>
STOMACH ULCERS OR INTESTINAL PROBLEMS?	<input type="checkbox"/>	<input type="checkbox"/>
GLAUCOMA?	<input type="checkbox"/>	<input type="checkbox"/>
FREQUENT OR RECURRING MOUTH SORES?	<input type="checkbox"/>	<input type="checkbox"/>
IMPLANTS/ARTIFICIAL JOINTS (HEART VALVE, HIP, KNEE)?.....	<input type="checkbox"/>	<input type="checkbox"/>
RADIATION (X-RAY TREATMENT FOR CANCER) IN HEAD OR NECK REGION? ...	<input type="checkbox"/>	<input type="checkbox"/>
NOISES IN JAW JOINT, PAIN NEAR EAR WHEN CHEWING, DO YOU GRIND OR CLENCH YOUR TEETH?	<input type="checkbox"/>	<input type="checkbox"/>
SINUS OR NASAL PROBLEMS?	<input type="checkbox"/>	<input type="checkbox"/>
ANY DISEASE, DRUG OR TRANSPLANT OPERATION THAT HAS DEPRESSED YOUR IMMUNE SYSTEM?	<input type="checkbox"/>	<input type="checkbox"/>
INFECTIONS OF ANY KIND?	<input type="checkbox"/>	<input type="checkbox"/>
ARE YOU USING ANY OF THE FOLLOWING MEDICATIONS?		
ANTIBIOTICS?	<input type="checkbox"/>	<input type="checkbox"/>
ANTICOAGULANTS (BLOOD THINNERS)?	<input type="checkbox"/>	<input type="checkbox"/>
THYROID MEDICATIONS?	<input type="checkbox"/>	<input type="checkbox"/>
ANTIHISTAMINES, DECONGESTANTS?	<input type="checkbox"/>	<input type="checkbox"/>
HIGH BLOOD PRESSURE OR HEART?	<input type="checkbox"/>	<input type="checkbox"/>
STEROIDS?	<input type="checkbox"/>	<input type="checkbox"/>
TRANQUILIZERS, ANTIDEPRESSANTS?	<input type="checkbox"/>	<input type="checkbox"/>
STOMACH OR GI MEDICATIONS?	<input type="checkbox"/>	<input type="checkbox"/>
CHOLESTEROL REDUCING DRUGS?	<input type="checkbox"/>	<input type="checkbox"/>
ASPIRIN, IBUPROFEN, NSAIDS OR ANTI-INFLAMMATORY DRUGS, NARCOTICS OPIOIDS, OR OTHER PAIN RELIEVERS?	<input type="checkbox"/>	<input type="checkbox"/>
WEIGHT REDUCTION PILLS OR DIET AIDS (OVER THE COUNTER OR NATURAL)?	<input type="checkbox"/>	<input type="checkbox"/>
VITAMINS, NATURAL REMEDIES (GINKO BILOBA, EPHEDRA, GINSENG, ETC)?	<input type="checkbox"/>	<input type="checkbox"/>
MARAJUANA, COCAINE OR OTHER "RECREATIONAL" DRUGS?	<input type="checkbox"/>	<input type="checkbox"/>

ANY OTHER REGULAR MEDICATIONS, PILLS, SUPPLEMENTS OR DRUGS?

PLEASE LIST ALL CURRENT MEDICATIONS:

ARE YOU ALLERGIC TO OR HAVE YOU EVER HAD AN ALLERGIC REACTION FROM ANY OF THE FOLLOWING:

	YES	NO
LOCAL ANESTHETIC (NOVOCAIN-LIKE DRUGS)?	<input type="checkbox"/>	<input type="checkbox"/>
PENICILLIN, AMOXICILLIN, CEPHALOSPORIN?	<input type="checkbox"/>	<input type="checkbox"/>
OTHER ANTIBIOTICS?	<input type="checkbox"/>	<input type="checkbox"/>
BARBITUATES, SEDATIVES?	<input type="checkbox"/>	<input type="checkbox"/>
ASPIRIN, IBUPROPHEN, NSAIDS OR OTHER PAIN MEDICATIONS?	<input type="checkbox"/>	<input type="checkbox"/>
CODINE, OTHER NARCOTICS, OR OPIOIDS?	<input type="checkbox"/>	<input type="checkbox"/>
LATEX?	<input type="checkbox"/>	<input type="checkbox"/>
PLEASE LIST ANY OTHER ALLERGIES:		

DO YOU HAVE HAY FEVER, FREQUENT SKIN RASHES, ETC?.....	<input type="checkbox"/>	<input type="checkbox"/>
DO YOU USE ALCOHOL? DRINKS PER DAY.....	<input type="checkbox"/>	<input type="checkbox"/>
DO YOU SMOKE?	<input type="checkbox"/>	<input type="checkbox"/>
WHAT PRODUCT AND HOW MUCH PER DAY?..... HOW LONG.....		
DO YOU USE SPIT TOBACCO?	<input type="checkbox"/>	<input type="checkbox"/>
DO YOU HAVE ANY OTHER DISEASES, CONDITIONS, OR PROBLEMS NOT LISTED THAT YOU THINK THE DOCTOR SHOULD KNOW ABOUT?	<input type="checkbox"/>	<input type="checkbox"/>
DO YOU WISH TO TALK TO THE DOCTOR PRIVATELY ABOUT SOMETHING?	<input type="checkbox"/>	<input type="checkbox"/>

WOMEN:

ARE YOU TAKING BIRTH CONTROL PILLS?	<input type="checkbox"/>	<input type="checkbox"/>
ARE YOU PREGNANT, TRYING TO BECOME PREGNANT, OR IS THERE ANY POSSIBILITY OF BEING PREGNANT?	<input type="checkbox"/>	<input type="checkbox"/>
ARE YOU BREASTFEEDING?	<input type="checkbox"/>	<input type="checkbox"/>
ARE YOU TAKING HORMONAL REPLACEMENTS?	<input type="checkbox"/>	<input type="checkbox"/>

ANY ADDITIONAL COMMENTS?

I UNDERSTAND THE IMPORTANCE OF A TRUTHFUL HEALTH HISTORY AND REALIZE THAT INCOMPLETE INFORMATION MAY HAVE AN ADVERSE EFFECT ON MY TREATMENT. TO THE BEST OF MY KNOWLEDGE, THE INFORMATION ABOVE IS COMPLETE AND ACCURATE.

DATE _____

SIGNATURE OF PERSON COMPLETING FORM _____

DR'S INITIALS _____

PLEASE SIGN & DATE BELOW

HIPPA PATIENT ACKNOWLEDGEMENT

I HAVE READ DR. THOMAS NOTICE OF PRIVACY PRACTICES AND ACKNOWLEDGE AND RECEIVING A COPY.

PATIENT NAME: _____

SIGNATURE: (of parent/guardian if under 18) _____

DATE: _____

PATIENT INFORMATION

CHECK ONE: MR. MRS. MS. DR.

TODAY'S DATE: _____ / _____ / _____

Name: _____

SSN: _____

Address: _____

Date of Birth: _____ / _____ / _____

City/State/Zip: _____

E-mail Address: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Occupation: _____ Employer: _____

Whom may we thank for referring you to our office? _____

Hobbies, Interests, Sports: _____

INSURANCE INFORMATION

Do you have vision insurance? No Yes (co-pays are due the day services are provided)

If yes, insurance company name: _____

Name of Insured: _____

Insured's date of birth: _____

Member's ID number: _____

Plan name: _____

Group number: _____

RESPONSIBLE PARTY

Name of person responsible for this account: _____

Relationship to patient: _____

Phone number: _____

Address: _____

City/State/Zip: _____

Name of employer: _____

Work phone: _____

HEALTH HISTORY

Reason for today's exam: _____

When was your last vision exam? _____

Eye Doctor: _____

Name of Medical Doctor: _____

Do you have any allergies to medications? No Yes If yes, explain: _____

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies): _____

List all major injuries, surgeries, and/or hospitalizations you have had: _____

List any of the following you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury: _____

Are you pregnant and/or nursing? No Yes

Do you wear glasses? No Yes If yes, how old is your present pair of lenses? _____

Do you wear contact lenses? No Yes If yes, how old is your present pair of lenses? _____

Type of contact lenses: Rigid Soft Extended Wear Other Are they comfortable? Yes No

FAMILY HISTORY

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

DISEASE/CONDITION	NO	YES	?	RELATIONSHIP TO YOU
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

REVIEW OF SYSTEMS

Do you currently, or have you ever had any problems in the following areas:

SYSTEM	NO	YES	?	NO	YES	?
CONSTITUTIONAL						
Fever, Weight Loss/Gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
INTEGUMENTARY (Skin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
NEUROLOGICAL						
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
EYES						
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Distorted Vision/Halos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Sandy or Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Excess Tearing/Watering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Glare/Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Eye Pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Chronic Infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Sties or Chalazion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Flashes/Floaters in Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
ENDOCRINE						
Thyroid/Other Glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
EARS, NOSE, MOUTH, THROAT						
Allergies/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Post-Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Dry Throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
RESPIRATORY						
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
VASCULAR / CARDIOVASCULAR						
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Heart Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
GASTROINTESTINAL						
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
GENITOURINARY						
Genitals/Kidney/Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
BONES / JOINTS / MUSCLES						
Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
LYMPHATIC / HEMATOLOGIC						
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
ALLERGIC / IMMUNOLOGIC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
PSYCHIATRIC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			

If you answered YES to any of the previous question regarding your health history or you have a condition not listed, please explain & list medications: _____

SOCIAL HISTORY

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

Yes, I would prefer to discuss my Social History information directly with my doctor. (check box)

Do you drive? Yes No

If yes, do you have visual difficulty when driving? Yes No

If yes, please describe: _____

Do you use tobacco products? No Yes If yes, type/amount/how long: _____

Do you drink alcohol? No Yes If yes, type/amount/how long: _____

Do you use illegal drugs? No Yes If yes, type/amount/how long: _____

Have you ever been exposed to or infected with: Gonorrhea Hepatitis HIV Syphilis None

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

A DETAIL OF MY RIGHTS AND HOW MY MEDICAL INFORMATION WILL BE USED AND DISCLOSED BY THOMAS EYE CARE IS SET FORTH IN THE NOTICE OF PRIVACY PRACTICES. A COPY HAS BEEN FURNISHED TO ME AND IS POSTED IN THE CLINIC.

I UNDERSTAND AND AGREE THAT REGARDLESS OF MY INSURANCE STATUS, I AM ULTIMATELY RESPONSIBLE FOR MY BALANCE ON MY ACCOUNT FOR ANY SERVICES I HAVE RENDERED.

I HAVE COMPLETED THE ABOVE QUESTIONS AND CERTIFY THIS INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL NOTIFY YOU OF ANY CHANGES IN MY INSURANCE STATUS OR ANY OF THE ABOVE INFORMATION. I REQUEST THAT PAYMENT OF AUTHORIZED MEDICAL BENEFITS, IF ANY, BE MADE TO THOMAS EYECARE ON MY BEHALF FOR ANY UNPAID SERVICES RENDERED BY PHYSICIAN.

I AUTHORIZE RELEASE OF MEDICAL INFORMATION TO THE HEALTH PLAN INDICATED FOR INFORMATION REQUESTED BY THE HEALTH PLAN TO DETERMINE THE PAYMENT OF MEDICAL BENEFITS.

I ACKNOWLEDGE RECEIPT OF THE NOTICE OF PRIVACY PRACTICES.

SIGNATURE

DATE