PANTON EYE CENTER

7740 North Avenue • Elmwood Park Illinois 60707-4124

(708) 452-7200 • Fax (708) 452-5777

DATE ________

NAME: ______________________ AGE ____________ SEX ________

ADDRESS: ______________________ BIRTH DATE ____________

CITY, STATE ______________________ ZIP CODE ____________

PHONE NUMBER ______________________ OCCUPATION ____________

CELL# ______________________ REFERRED BY ____________

EMAIL ADDRESS ______________________ SOCIAL SECURITY # ____________

PRIMARY CARE PHYSICIAN ____________

INSURANCE INFORMATION:

INSURANCE COMPANY ______________________ GROUP NAME/# ____________

POLICY HOLDER'S NAME ______________________

POLICY HOLDER'S SOCIAL SECURITY NO. ______________POLICY HOLDER'S BIRTH ________

Are you taking medications? Yes —— No ——

If so, what kind? ______________________

Are you allergic to any medications? Yes —— No ——

If so, what kind? ______________________

Do you have Diabetes? Yes —— No ——

Please state any other medical problems ______________________

Is there a history of Glaucoma in your family? Yes —— No ________

If so, what family member? ______________________

Have you ever had any type of Eye Surgery? Yes —— No ——

If so, what kind? date? ______________________

Are you here for a General Eye Examination? Yes —— No ——

Do You want information concerning LASIK? Yes —— No ——

Was this an Eye injury? ____Yes ____ No If so, was it work related? Yes ________ No ________

If so, please explain ______________________

If you are having any specific problems with your Eyes please explain ______________________

____

Do you wear glasses? ______ Yes ______ No How old are they? ____________

Do you wear contacts? ______ Yes ______ No How old are they? ____________

Preferred Pharmacy ______________City______________Phone____________

EMPLOYER ______________________ WORK PHONE ____________

EMPLOYER'S ADDRESS ______________________

CITY, STATE, ZIP CODE ______________________

SIGNATURE ______________________ DATE____________

CONSENT FOR MEDICAL CARE AND RELEASE OF RECORDS

I give my permission for medical care, including recording of my medical history, physical examinations, Laboratory tests, and x-ray films: any of which may help evaluate my condition, plan treatment, or evaluate it's results.

I have been informed that written and computerized records regarding my illness, treatment, and follow-up will be kept by both my doctors and their staff. I also understand that computer access to and/or copies of these records which may include pathology slides, x-rays and associated reports may be provided to authorized medical personnel at affiliated institutions where I may continue my treatment.

I am aware of the fact that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me in terms of treatment or examination.

My medical records may be used by Dr. Panton and my insurance carrier for auditing as well as billing purposes to improve the efficiency and quality of healthcare.

____

(Name of Patient)

Signature: ______________________________ Date: ____________________

Relationship if not self: ____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I ________________________________ acknowledge that I have received a copy of
(Name of Patient)

Panton Eye Center's Notice of Privacy Practices. This Notice describes how Panton Eye Center may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

____

(Signature of Patient, or Personal Representative) (Date)

____

(Relationship to Patient)

ACKNOWLEDGEMENT OF OFFICE PROCEDURES

INSURANCE: Patients at this practice may have medical insurance, vision insurance, both or neither. The Panton Eye Center will bill the appropriate insurance based upon your complete medical findings. We can not bill vision insurance when a medical diagnosis is identified and that diagnosis requires more extensive care.

GLASSES: The Panton Eye Center can not cancel an order for glasses once an order has been placed.

I UNDERSTAND AND AGREE TO ALL OF THE ABOVE PRACTICES.

SIGNATURE____