ANNANDALE
EYE CLINIC

Patient's Occupation or School Grade:	**Patient's Employer or School:**	**Patient's Medical Physician & Clinic:**
Patient's Pharmacy:	**Employers Phone Number:**	**Clinic Phone Number:**
Emergency Contact Name:	**Emergency Contact's Relation to Patient:**	**Emergency Contact Phone Number:**

What recreational hobbies do you enjoy participating in? (Please check all that apply)

- ❑ Sports
- ❑ Computer
- ❑ Cooking
- ❑ Reading
- ❑ Crafts/Sewing
- ❑ Video Games
- ❑ Boating/ Fishing
- ❑ Gardening
- ❑ Snow Sports
- ❑ Hunting
- ❑ Woodworking
- ❑ Musical Instruments

Are or have you been recently experiencing any of the following difficulties? (Please check all that apply)

- ❑ Blurry Vision
- ❑ Sensitivity to Sunlight
- ❑ Eye Fatigue
- ❑ Dry Eyes
- ❑ Eye Strain
- ❑ Other_____
- ❑ Night Time Driving/ Glare
- ❑ Headaches

Amount of screen time per day? (Including TV, Computer, and Phone)

- ❑ Minimal/ None
- ❑ 3-5 Hours
- ❑ 5+ Hours

RELEASE OF INFORMATION/ GUARANTEE OF PAYMENT

I, the undersigned, authorize Annandale Eye Clinic, it's physicians and/or employees to apply for benefits on my behalf for services rendered to me. I request that payment from my insurance carrier be made directly to Litchfield Eye Center. I certify that the above information is correct and authorize the release of any information to my insurance carrier. I understand the HIPAA compliance regulations and agree to them. I also authorize Litchfield Eye Center, it's physicians and/or employees to disclose any part of or all of the medical records to my insurance carrier, and understand that it may be necessary to contact my present or past employer in regard to insurance claims. I, the undersigned, also understand that I am financially responsible for all charges not covered by my insurance and/or Medicare. I further understand that my health insurance may not cover all services including, but not limited to: refractions, RHA retinal exam, routine eye exams, eye glasses, and other ancillary services; some of these services are necessary for the completion of the evaluation. I UNDERSTAND THAT IF MY INSURANCE COMPANY DENIES SERVICE, THEN IT WILL BE MY RESPONSIBILITY TO PAY THESE CHARGES.

_____ _____

SIGNED BY **DATE**

--Office Use Only--

INS_____
COPAY_____
RHA ---S---- M----- N
CL EXAM Y-----N
OCT S----M-----N

PAST GLASSES
YEAR_____
LENS_____
AR_____
SUN_____

RTC- 1-- 3-- 6
VF
OCT
IOP

GLASSES
CONTACTS
TRIALS-
BOXES-