Welcome to Drs. Babington and Babington, Optometrists

□Dr. □Mr. □ Mrs. □Single □Married □Divorced **Gender:** □Male / □Female **Date of Birth**
□Ms. □Miss □Other_____ □Widowed □Legally Separated (as shown on insurance) ___/___/_____

Last Name _____ **First Name** _____ **MI**_____

Address_____ **City**_____ **State**_____ **Zip**_____

Mobile #_____ **Work#**_____ **Home#**_____

Employer_____**Occupation**_____

Social Security Number_____-_____-_____ **Email**_____

Race: □American Indian □Asian □African American □Hispanic □Pacific Islander □Caucasian **Ethnicity:** □Hispanic □Non-Hispanic

Vision Insurance: □None □VSP(Vision Service Plan) □Davis □EyeMed □Spectera □SVS (Superior Vision Service)

Member_____ **Relation**_____ **DOB**_____ **ID/SSN**_____

I authorize Drs. Babington and Babington to release my personal health information (example: Glasses or Contact Lens Rx, billing information, dispensing of physical glasses or contacts) to the following individuals.

Name_____ Relationship to Patient_____

Name_____ Relationship to Patient_____

Name_____ Relationship to Patient_____

_____ Initial **Payments and Co-Payments:** All required Payments, co-payments, deductibles and other out of pocket expenses are due in full at the time services are rendered or materials are provided, unless specific financial agreements have been made prior to your scheduled appointment. The office accepts VISA, Mastercard, debit cards, cash and personal checks with proper identification. All personal checks returned for any reason are subject to a $25.00 service charge without exception. In the event of nonpayment, the cost of collection and or court costs and reasonable legal fees is the responsibility of the patient. **I understand that there are no refunds offered on Professional Services, Contact Lenses or Glasses.**

_____ Initial **Vision Plan and Insurance Benefits:** It is your responsibility to understand the nature of your vision plan and insurance benefits prior to your scheduled appointment. The employees of Drs. Babington and Babington will to the best of their knowledge and understanding help answer any questions you may have regarding your vision plan and insurance benefits; however, no guarantee of accuracy regarding eligibility, coverage, or benefit information can be made by anyone other than your vision plan or insurance carrier directly. I agree to pay Drs. Babington and Babington (in full) within 30 days of notification of nonpayment by my vision plan.

_____ Initial **Assignment of Benefits:** I authorize assignment of vision plan and insurance benefits to Drs. Babington and Babington for the purpose of determining eligibility benefits and collecting for all services rendered and materials provided. In addition, I authorize Drs. Babington and Babington and any of its employees to furnish information concerning my present condition to insurance companies and referring doctors as deemed necessary. I authorize this "Signature on File" form to be used in place of the original. I will permit a copy of this form, digital or paper may be used in place of the original.

_____ Initial **HIPAA Compliancy:** I acknowledge that I have received a copy of the Notice of Privacy Practices (HIPAA) for this office. I have read and understood the terms and conditions outlined above, and I hereby certify that all the information provided is true and accurate to the best of my knowledge and understanding. (HIPAA form is also available via www.drbabington.com)

Patient Signature:_____ **Date:**_____

Or Name and Signature of Guardian & Relationship _____

Name:_____ **DOB:**_____

Health History:	Self Y	Self N	Family History *Relationship to you*		Self Y	Self N	Family History *Relationship to you*
Integumentary (Skin)	□	□	_____	Thyroid Disorder	□	□	_____
Headaches	□	□	_____	Psychiatric	□	□	_____
Migraines	□	□	_____	Other Health Issues	□	□	_____
Ear Nose Mouth Throat	□	□	_____	Eye Infections	□	□	_____
Arthritis	□	□	_____	Macular Degeneration	□	□	_____
Asthma/ Lung Disease	□	□	_____	Blindness	□	□	_____
Cancer	□	□	_____	Cataracts	□	□	_____
Diabetes Type 1	□	□	_____	Crossed Eyes	□	□	_____
Diabetes Type 2	□	□	_____	Retinal Issues	□	□	_____
High Blood Pressure	□	□	_____	Lazy Eye (Amblyopia)	□	□	_____
Heart Disease	□	□	_____	Glaucoma	□	□	_____
Elevated Cholesterol	□	□	_____	Eyelid Issues	□	□	_____
Gastrointestinal	□	□	_____	Keratoconus/Cornea	□	□	_____
Kidney Disease	□	□	_____	Eye Injury	□	□	_____
Lupus	□	□	_____	Other Eye Issues	□	□	_____

Are you pregnant or nursing? □No □Yes… If yes, how many weeks along are you?_____
Medication Allergies: □None □Penicillin □Sulfa Drugs □Other_____
List any medications you currently take (including birth control, OTC medications, ANY eyedrops, home remedies)
□None or List:_____
_____
List all Major Surgeries, Hospitalizations including EYE injuries / Surgery (Cataract, LASIK / PRK) you have had:
□None or List:_____
_____

How do you use your eyes at work: □Computer □Outdoors □Reading □Safety Glasses □Other_____
Do you wear glasses? □No □Yes… how old is your current pair of glasses?_____
Do you wear contact lenses? □No □Yes… **Type of Lens:** □Soft □Toric (for astigmatism) □Multifocal/Monovision □Gas Perm
How often do you replace your lenses? □Daily □2 weeks □Monthly □3 months □Other_____
Do you sleep in your lenses? □No □Yes **What is the brand of contact lenses worn?**_____

Please list any hobbies you enjoy_____
Do you drink alcohol? □No □Yes… How often □Social Use □1-2 drinks daily □Dependent □Other_____
Do you use tobacco products? □No □Former User □Yes… How often? □Less than 1pk day □ 1-2 pk day □More than 2pk day
Do you use recreational drugs (including marijuana)? □No □Recreational Use □Dependent Type:_____
Have you ever been exposed / infected with: **STDs?** □No □Yes **Blood Transfusion?** □No □Yes

Patient Signature:_____ **Date:**_____
Or Name and Signature of Guardian & Relationship _____

Medical History Update:

Date:_____ Comments:_____Initial:_____
Date:_____ Comments:_____Initial:_____
Date:_____ Comments:_____Initial:_____
Date:_____ Comments:_____Initial:_____
Date:_____ Comments:_____Initial:_____
Date:_____ Comments:_____Initial:_____