Mr., Ms., Mrs., Miss, Master, Dr., (Please circle one) Date_____

Name (last, first)_____ Birthdate_____

Address_____

City_____State_____Zip_____Phone_____

Work #_____Cell #_____Email_____

Occupation_____Social Security#_____

Employer_____Address_____

Spouse_____ Children_____

In case of emergency, contact_____Phone_____

Whom may we thank for your referral?

Responsible Party/ Insurance Info

Person responsible for payment_____Relationship_____

Billing address (if different from above)_____

City_____State_____Zip_____Phone_____

Social Security#_____Birthdate_____

Employer_____Address_____

Primary Vision Insurance_____Phone_____

Policy Number_____Group Number_____

Secondary Vision Insurance_____

Policy Number_____Group Number_____

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on both sides of this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

Signature_____Date_____

When was your last complete eye exam?_____Name of doctor_____

When was your last complete physical?_____Name of doctor_____

Have you ever had an eye injury, eye surgery, or been treated for any eye disease?_____Y_____N

Is there ANY history of high blood pressure, heart disease, diabetes, or glaucoma in your family?_____Y_____N

Has anyone in your family had eye surgery or been treated for any eye disease?_____Y_____N

Does your occupation require safety eyewear?_____Y_____N Do you use a computer at work or home?_____Y_____N

Please list your hobbies_____

Do you use safety eyewear for any of your hobbies?_____Y_____N

Do you experience: (please check all that apply)

_____Eyes strain, red, or itch _____Watery eyes _____Double vision

_____Sandy or dry eyes _____Light or Glare sensitivity _____Learning Disability

Are you interested in: (please check all that apply)

_____Extra light, durable frames _____No-line bifocals _____UV protection

_____Allergy-free frames _____Extra thin, durable lenses _____Scratch-Resistant lenses

_____Protective sunglasses _____Anti-reflective lenses _____Contact lenses soft/hard

THANK YOU!!!

RECEIPT OF NOTICE OF PRIVACY POLICIES & CONSENT FORM

Eye Zone Optometry, Inc.
3871 Pacific Coast Hwy
Torrance, CA 90505

Phone: 310-375-9230
Fax: 310-375-9420
Email: eyezoneoptometry@gmail.com

Patient Name:_____ Phone:_____

Our commitment at Eye Zone is to serve our patients with professionalism and caring, being sure at all times to protect the privacy and security of all Protected Health Information.
In the course of providing service to you, we create, receive, and store health information that identifies you. The provided ***Notice of Privacy Policies*** describes these uses and disclosures of information in detail. You are free to read this notice and/or take it with you before you sign this form. It may be necessary, when applicable, to use and disclose this health information in order to (1) provide treatment/s for you (2) make orders with laboratories (3) co-manage care with another health professional (4) submit claims to third-party payers, insurers, or their auditors for claims review, determination of benefits, and payment.

The following declaration applies when we are submitting an insurance claim on you behalf:

> "I hereby instruct and direct _____ insurance company to pay by e-check or paper check made out and mailed to Eye Zone Optometry, Inc. at 3871 Pacific Coast Hwy, Torrance, CA 90505. If my current policy prohibits direct payment to doctor, I hereby also instruct and direct you to make out the check to me and mail it to Eye Zone Optometry, Inc. at 3871 Pacific Coast Hwy, Torrance CA 90505 for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. I have agreed to pay, in a current manner, any balance of said professional services charges over and above this insurance payment. A photocopy of this Assignment shall be considered as effective and valid as the original. I authorize Eye Zone Optometry, Inc. to initiate a complaint to the Insurance Commissioner for any reason on my behalf."

You have the right to ask us to restrict the uses or disclosures, but as described in our ***Notice of Privacy Practices***, we are not obliged to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our Notice of Privacy Practices describes how to ask for a restriction.

*I have read this document and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations. I acknowledge that a copy of Eye Zone's Notice of Privacy Practices has been made available to me.

_____ _____
Signature Date

If you are signing as a personal representative of the patient, describe the relationship to the patient.

_____ _____
Relationship to Patient Print Name