J. Ellis Cosby, O.D., P.C.

Please complete the following information.

Date_______________Birthdate_______________ Male / Female Single/Married/Divorced/Widowed
Name_____________________________Parents name if patient is a minor_________________________________
Address_______________________________City_________________________State_____Zip_________________
Home phone__________________ Work phone__________________ Cell phone___________________
EMAIL: (REQUIRED FOR PATIENT PORTAL):____
SSN___________________ Occupation________________________ Employer_____________________________
Insurance information: Vision Insurance: __________________________I.D.#_______________________
Major Medical Insurance____
When was your last eye exam?_____________Doctor?____
Do you wear glasses? Y /N Do you wear Contact lenses? Y / N
When was your last physical exam? ___________________Doctor?___________________________________
Are you currently taking any medications? Y / N If yes, please list__________________________
____

List medication allergies:____

Have you ever had any eye injuries/surgeries? Y / N

Do you have any of the following conditions?

Diabetes	Y / N	High blood Pressure	Y / N	Arthritis	Y / N
Glaucoma	Y / N	Fever	Y / N	Respiratory	Y / N
Heart Trbl	Y / N	Blood disorder	Y / N	Skin Trbl	Y / N
Muscle/skin	Y / N	Genitourinary Trbl	Y / N	Gastrointestinal	Y / N
Neurological	Y / N	Ear/Nose/Throat Trbl	Y / N	Psychological Trbl	Y / N
Sleep Apnea	Y / N				

Please list any medical conditions not listed above____
____
Please list any family member with the following conditions:
Diabetes___________________________________ Hypertension____
Heart Problems______________________________ Cataracts____
Blindness___________________________________ Glaucoma____
Crossed eyes_______________________________ Other____

Do you use tobacco products? Y / N (if yes, indicate type and amount)________________________
Do you drink alcohol? Y / N (if yes, indicate amount/how long)_______________________________

If patient is less than 6 years, did he or she have any problems before, during, or just after birth? ____

WE WILL FILE INSURANCE CLAIMS FOR PLANS THAT WE PARTICIPATE IN AS A COURTESY.

I UNDERSTAND THAT ALL CHARGES ARE MY RESPONSIBILITY regardless of insurance coverage, and that payment is due when services are rendered. A deposit of 50% or more is required in order for materials to be ordered. Materials must be picked up within 45 days of notification. After 45 days, unless other arrangements have been approved, the materials will be returned to the manufacturer and the deposit will be forfeited.

I ALSO UNDERSTAND THAT ALL INSURANCE COPAYS ARE DUE AT THE TIME OF SERVICE.

REFRACTION is the process of determining if there is a need for corrective eyeglasses. It is NOT covered by Medicare or any other health insurance plan, however it is covered by most vision plans. Our office fee for refraction is $40.00 and this fee is collected at the time of service.

Please list the names of individuals that you will allow to have access to your financial information in regards to J. Ellis Cosby, O.D., P.C.

______________________________ ______________________________

______________________________ ______________________________

Please list the names of individuals that you will allow to have access to your medical info.

______________________________ ______________________________

______________________________ ______________________________

Emergency contact:____

Please sign and date: Signature____________________Date____________

Signature____________________Date____________

Signature____________________Date____________

Signature____________________Date____________