WELCOME TO OUR OFFICE

MOCKSVILLE VISION CENTER

Steven G. Laymon, OD
Thomas A Bull, OD

198-B Hospital Street
Mocksville, NC 27028
(336) 751-5734

----------Office Use Only----------
Office Account #_____
Date _____

Patient Name: Mr. / Mrs. / Miss / Ms / Dr. _____
(*As listed on insurance card*) (Last) (First) (Middle/Maiden)

Name to be called by: _____ **Date of Birth**: _____ **Age**: _____
(Month / Day / Year)

Sex: [ ] Male [ ] Female **Marital Status**: [ ] Married [ ] Single [ ] Divorced [ ] Legally Separated [ ] Widowed

Ethnicity: [ ] Asian [ ] African American/Black [ ] Caucasian [ ] Hispanic [ ] Multiracial [ ] Other _____

Mailing Address: _____

Street Address (if different from mailing address):_____

City: _____ **State** :_____ **Zip**: _____

E-mail Address: _____**Cell Phone**: (_____)_____

Home Phone: (_____)_____**Work Phone**: (_____)_____

Emergency Contact: _____**Emergency Number**: (_____)_____

Employment Status: Employed: [ ]Full Time [ ]Part Time [ ] Self-employed [ ] Retired [ ] Unemployed
Student: [ ] Full Time [ ] Part Time [ ] Active Military Duty

Patient Employer: _____ **Occupation**:_____

Patient Employer Address:_____

Patient Social Security Number: _____

Responsible Party: _____**Please Circle**: Spouse Parent Guardian Other_____

Billing Address (If Different From Above):_____

Responsible Party Date of Birth: _____ **Work Phone**: (_____) _____

Responsible Party Employer:_____

Responsible Party Social Security Number:_____

Who recommended/referred you to our office? _____

What is the reason for today's visit?_____

Are you currently under a doctor's care for any medical problems? [ ] Yes [ ] No

If so, what? _____

Primary Physician: _____**City**:_____

Are you currently taking any medications or drugs? [ ] Yes [ ] No

If yes, what? _____

List Pharmacy Used:_____ **City**:_____

Do you have prescription insurance? [ ] Yes [ ] No **If yes, name of insurance plan** _____

Are you allergic to any medication? [ ] Yes [ ] No If so, what_____

Do you use tobacco? [ ] Yes [ ] No If so, how much per day?_____

Do you drink alcohol? [ ] Yes [ ] No How many drinks per week?_____

*****PLEASE TURN THIS FORM OVER AND COMPLETE THE BACK SIDE*****

Have you ever had any type of eye injury, eye surgery, or eye disease? _____

If so, what? _____

Have you ever worn glasses?	( ) Yes	( ) No
Do you presently wear glasses?	( ) Yes	( ) No
Are you planning on purchasing new glasses today?	( ) Yes	( ) No
Have you ever worn contact lenses?	( ) Yes	( ) No
Do you presently wear contact lenses?	( ) Yes	( ) No
Would you be interested in contact lenses?	( ) Yes	( ) No

Have you or anyone in your family had any of the following?

Diabetes (high blood sugar)	( ) Yes	( ) No	If yes, who? _____
Heart Disease	( ) Yes	( ) No	If yes, who? _____
Hypertension (high blood pressure)	( ) Yes	( ) No	If yes, who? _____
Cataracts	( ) Yes	( ) No	If yes, who? _____
Glaucoma	( ) Yes	( ) No	If yes, who? _____
Retinal Disease	( ) Yes	( ) No	If yes, who? _____
Macular Degeneration	( ) Yes	( ) No	If yes, who? _____

PAYMENT POLICY

Payment for professional services is required today. Glasses and contact lenses require a 50% deposit before ordering. The remaining balance is due when the glasses or contact lenses are dispensed..

Method of payment: ( ) Cash ( ) Visa / MasterCard / Discover / Debit Card
( ) Check ( ) Insurance Name _____

Please notify the receptionist of any insurance coverage or service organization that may assist with the payment of your account ***NOW BEFORE*** services are rendered. We file MEDICARE, MEDICAID, BCBS, STATE OF NORTH CAROLINA, and GROUP VISION PLANS of which we are a provider. Insurance information ***MUST*** be turned in on the day services are rendered. Please present your insurance information to the receptionist with this entrance form. If you do not have your insurance card with you today, we reserve the right to refuse to file your insurance if the information is not received in our office within thirty (30) days from the date of service. If a referral is required for your visit, it will be the patient's responsibility to see that we have it prior to filing the insurance. Please understand it is your responsibility to follow-up with your insurance company to be sure they are handling and paying your claim in an appropriate and timely manner. If payment is not made by your insurance within 90 days of the date of service, the unpaid insurance balance will become your responsibility to pay. Co-pays are due at the time of each visit.

INSURANCE RELEASE

I give my permission for Mocksville Vision Center to release to the Social Security Administration or other insurance carriers information concerning my insurance claim. I understand that my consent is good for all future services. I certify that the information I have given is correct.

_____ Date _____

Signature of Patient / Parent / Guardian

DILATION ADVISORY

As part of your exam today and any future exams, the doctor may dilate your eyes. This procedure may temporarily impair your near vision and increase your sensitivity to light. If you have had problems with this procedure in the past, please notify the doctor.

_____ Date _____

Signature of Patient / Parent / Guardian

Mocksville Vision Center
198-B Hospital Street
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(336) 751-5734

Notice of Privacy Practices Patient Acknowledgement

Patient Name: _____Date of Birth: _____

I understand Mocksville Vision Center's Notice of Privacy Practices written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. This includes, but is not limited to:

- A statement that this practice is required by law to maintain the privacy of protected health information
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
    - The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
    - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
    - The right to receive confidential communications of protected health information.
    - The right to inspect and copy protected health information.
    - The right to amend protected health information.
    - The right to receive an accounting of disclosures of protected health information.
    - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice Of Privacy Practices and to make new provisions effective for all protected health information that it maintains. If changes occur, this practice will provide me a revised Notice of Privacy Practices upon request.

Signature: _____ Date: _____

Relation to patient (if signed by a personal representative of patient): _____