RISK OPTOMETRIC ASSOCIATES, PA

PATIENT HISTORY

Are you here for: **Glasses exam** _____ **Contacts** ____ **Other Reason** ________________________

Name____ **Male** ________ **Female** ______

Address____ **Date of Birth** ___________________

City_____________________ **State** ______ **Zip** _______

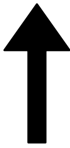
List ALL insurances _______________________________ **How much is your co-pay?** ________

Are you the Primary Insured or are you a family member? ____ **Primary** ____ **Family member (spouse / child)**

Home Phone: _______________________________

Cell Phone: ________________________________

Email:_____________________________________



We're **online**! **Confirm** your appointments via text or email! Your **email** is the only way we will send you a yearly reminder (not for soliciting)

Which of our offices was your last appointment?

Skibo / Hope Mills / Raeford / Ramsey / Yopp

Marine / Hendersonville / Ft. Bragg / Other

Office Name: __________________________

I know my HIPAA rights: ____ Yes

Personal Medical

Race:________________________________

Family Doctor ___________________(______Never ____ Don't remember) **Last Visit:** ________________

Last Eye Doctor _____________________(______Don't have one) **Last Eye Exam**________________________

What problems are you having today: ____

Are you Diabetic? __________ How Long?___________________

Any Major Health Problems with your eyes or general health?____

Any Major Family diseases or history of blindness?____

Occupation____

Are you Pregnant? _________ How far along?________________

Taking any Medication?__________________________________

Allergic to any Medicine?_______________________________

I understand and agree Risk Optometric will NOT fill out, file, or in way deal with insurance companies for my evaluation today. I understand and agree that the professional services provided to me are nonrefundable. Method of payment today must be in cash or credit card. We no longer accept checks. A service charge of 1 ½ % per month, 18% APR will be added to overdue accounts. Also liable for legal and collection fees.

Signature____Date__________________

RISK OPTOMETRIC
ASSOCIATES, PA

Waiver of Comprehensive Eye Exam

I have been informed and understand the importance of a comprehensive eye examination and that this includes dilation of the pupils with medication along with other tests to allow a thorough evaluation of the eyes for sight-threatening diseases that may be undetectable without these appropriate tests. I further understand and agree that Risk Optometric Associates, PA, and the doctor evaluating me today, accepts no responsibility for the examination performed by any other person, and I do hereby release and forever discharge Risk Optometric Associates, PA, and the doctor evaluating me today, from any and all claims, demands, damages, or actions at law and any consequential damage on account of my refusal to allow a comprehensive eye exam. I also agree to hold harmless Risk Optometric Associates, PA, and the doctor performing my evaluation, from any claims or expenses incurred in defense of any such actions, including any suit from contribution and/or indemnification.

I further certify that a dilated eye examination has been offered to me and I have **DECLINED** at the present time, and I do not wish to return for the dilation at a later time.

I certify that I HAVE **READ THE ABOVE** and have signed this document fully understanding its content and meaning. I acknowledge that this document is signed as consideration by honoring my request **NOT** to be dilated or have a comprehensive eye exam.

Signature_________________________________ Date_____________________________

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Waiver of Insurance Claim

I, __________________________, understand that by signing this form I am waiving my right to use any insurance I may have to cover the procedures today. My charges will not be billed to my insurance company, and I will not receive credit towards my deductible if need apply. I also understand that since I am declining to use my insurance, payment is due at the time services are rendered.

Patient's Name (print) _______________________________________

Patient's Signature ____

Date ____

Staff Signature____