Welcome Back to the Office of Troy A. Norton O.D.

www.nortoneyecare.com

CURRENT PATIENT UPDATE

Patient Name _____ MI _____ Today's Date _____/_____/_____

Date of Birth _____/_____/_____ Sex ☐ M ☐ F Social Security Number _____-_____-_____

Mailing Address: _____ Physical Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell_____ Work _____

E-mail Address _____

Employer _____ Occupation _____

Communication Preference: ☐ Mail ☐ Email ☐ Text ☐ Phone Married ☐ Yes ☐ No Spouse's Name _____

Name of Legal Guardian/Responsible party (if patient is a minor) _____ *D.O.B.* _____

Relationship to patient _____ *Address if different than patient* _____

INSURANCE UPDATE

Insurance (Medical) _____ (Vision) _____

Subscriber's Name _____ Subscriber's Date of Birth _____/_____/_____

Subscriber's Social Security Number _____-_____-_____ Subscriber's Employer _____

Subscriber's Address _____

PERSONAL EYE INFORMATION

Are you experiencing any of the following?

Loss or change of vision	No	Yes
Blurry Vision	No	Yes
Injury to affected eye	No	Yes
Pain or irritation	No	Yes
Watery eyes	No	Yes
Discharge	No	Yes
Discoloration of eye	No	Yes
Flashes or Floaters	No	Yes

Other _____

SOCIAL HISTORY

Do you currently smoke? ☐ Yes ☐ No

If yes, how long have you smoked? _____

Packs per day: _____

Have you previously smoked? ☐ Yes ☐ No

If yes, when did you quit? _____

CURRENT HEALTH HISTORY

Has there been any change in your medical history since we last saw you?

☐ Yes ☐ No

If yes, please explain:_____

_____

Height: _____ **Weight:** _____

Please provide us with a medication list!

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

I authorize Dr. Troy A. Norton O.D. or my insurance company to release any information needed to process my claims. I understand that I am financially responsible for any co pay, co-insurance, deductible, and other non covered services or materials the day services are rendered. I also understand I am financially responsible for any balance remaining after my claim has been processed.

PLEASE SIGN HERE Patient/Guardian Signature _____ **Date** _____/_____/_____

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I acknowledge I have been offered or received a copy of this practice's NOTICE OF PRIVACY PRACTICES. Private pay patients have the right to instruct Dr. Norton not to share information about treatment to their insurance company.

I do _____ I do NOT _____ wish to have information about my treatment shared with my insurance company

PLEASE SIGN HERE Patient/Guardian Signature _____ **Date** _____/_____/_____