East Location
1200 E. Main Street, Ste. 3
Spartanburg, SC 29307
(864) 585-7807
www.spartanburgvision.com

Spartanburg VISION
*Our **vision** is to protect **yours***

West Location
227 E. Blackstock Road, Ste.200
Spartanburg, SC 29301
(864) 576-0564
www.spartanburgvision.com

Date: ____ / ____ / ____

Name: Last _____ First _____ M.I. _____ Preferred Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home / Mobile Phone: _____ Texting Okay? Y / N Work Phone: _____

Date of Birth: _____ / _____ / _____ Age _____ Male / Female SS#: _____

Employer: _____ Occupation: _____ Email: _____

Who is the insurance policy holder?

☐ Self ☐ Other: Insured's Name: _____ Insured's DOB: ____ / ____ / ____

Insured's SSN: _____ Relationship to patient: _____

Name of Primary **Medical** Insurance Carrier: _____ ID #_____

Name of Secondary **Medical** Insurance Carrier: _____ ID # _____

Name of **Vision** Insurance Carrier: _____ ID # _____

~ You will be responsible for any portion of your bill which is not paid for by your insurance company.~

Eye History

Why did you schedule your visit today? _____

Do you want to be fitted for contacts today? Yes / No / Clear / Color

Please check any of the following that apply

☐ Blurry Distance Vision	☐ Burning Eyes	☐ Floaters or Spots	☐ Light Sensitive
☐ Blurry Near Vision	☐ Itchy Eyes	☐ See Flashes	☐ Mucous Discharge
☐ Double Vision	☐ Watery Eyes	☐ Loss of Vision	☐ Crossed Eyes
☐ Eye Strain	☐ Dry Eyes	☐ See Halos	☐ Headaches
☐ Eye Pain / Soreness	☐ Red Eyes	☐ Poor Night Vision	☐ Droopy Lid
☐ Tired Eyes	☐ Sandy/Gritty Feeling	☐ Glare or Reflection	☐ None of the Above

Personal Medical History

For the following categories, please list any changes that have occurred since your last visit with us:

Medications: None / _____

Medication Allergies: None / _____

Surgeries: None / _____

Are you being treated for any new medical conditions: No / _____

Current Height: _____ Current Weight: _____ Do you currently smoke cigarettes? Yes / No

Authorization for Release of Information

This form authorizes MacMillan Optical to release protected information about the patient named below to the people listed (e.g. spouse, parent, sibling) by means of phone calls and voice mails/answering machine messages.

I consent to the release of (please check all that apply):

- ☐ Financial/Billing Information
- ☐ Medical Care (treatments plans, medications, procedures, appointments, test results, etc.)

This information may be released to the following:

- ☐ Patient's voice mail/answering machine
- ☐ Voice mail/answering machine of (e.g. spouse, parent sibling):

_____ _____
Name/Relationship to patient Phone

_____ _____
Name/Relationship to patient Phone

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in the document by sending a written notification to MacMillan Optical. I understand that a revocation is not effective in cases where the information has already been disclosed.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned upon signing. This authorization shall be in effect until revoked by the patient.

X_____
Signature of Patient (parent or legal guardian if minor)

Notice of Privacy Practices

MacMillan Optical will provide me a copy of their Notice of Privacy Practices upon request. _____
(Please Initial)

Statement of Financial Responsibility and Assignment of Insurance Benefits

I understand that I am financially responsible for all charges not paid by insurance. I authorize the release of information to my insurance company for insurance/medical purposes. I hereby authorize payment from my insurance company to MacMillan Optical.

X_____ _____ _____
Signature of Patient (legal guardian if minor) Print Name Date

_____ _____ _____
Address SSN Date of Birth