The United Sates government is requiring optometry practices to collect the following information on our patients. These are the same questions that were asked on the U.S. Census.

General Patient Information

Last Name: _____First Name: _____ M: ____Nickname: _____

Address: _____ City: _____ State: _____Zip: _____

Date of Birth: _____ SSN: _____Primary Phone: _____

Secondary Phone: _____ Email: _____

Primary Dr.: _____ Location: _____ Phone: _____

Preferred Pharmacy: _____ Location: _____ Phone: _____

Employer: _____ Occupation: _____

Best Method of contact (Circle all that applies): Call Text E-mail

Check all that applies:
Race: □ Native or Alaskan Native □ Asian or Pacific Islander □ African American □ White □ Other □ Decline to Answer
Ethnicity: □ Not Hispanic or Latino □ Hispanic or Latino □ Unknown □ Decline to Answer
Special Needs: □ Hearing Impaired □ Translator □ Wheelchair □N/A
Marital Status: □ Married □ Single □ Widowed □ Divorced □ Minor □ Male □ Female □ Student □ Other

Insurance Information

Name of Primary Person: _____ SSN: _____ Date of Birth: _____

Address: _____ City: _____ State: _____Zip: _____ Phone: _____

Primary Person's Employer: _____ Relationship to Patient: _____

Health/Medical Insurance Name: _____ Member ID#: _____ Group #: _____

Vision Insurance Name: _____ Member ID#: _____ Group #: _____

General Health History

Smoking: □ Yes □ No Chewing Tobacco: □ Yes □ No Using Recreational Drugs: □ Yes □ No Drinking: □ Yes □ No

Asthma: □ Yes □ No Diabetic: □ Yes □ No High Blood Pressure: □ Yes □ No High Cholesterol: □ Yes □ No

Exercise Regularly: □ Yes □ No

Allergic to Medication: □ Yes □ No If yes, please list: _____

List of any prescribed medication: _____

_____

Permission to Disclose Confidential Information

I, _____ hereby authorize Jury Eye Care LLC to disclose medical records to:

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Or

_____ I do not wish to have my information released

Medical records are protected by HIPAA, federal regulation and Kansas Statutes, and further disclosure is prohibited without the consent of the undersigned.

This authorization is subject to cancellation at any time, but does not apply to any information already released in good faith.

This notice shall remain in effect until changed or revoked in writing by the patient.

_____ _____

Signature of Patient Date

_____ _____

Signature of parent, guardian or authorized rep. Witness