jury eyecare

The United States 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: _____ MI: ___ Nickname: _____

Address: _____ City/State/Zip: _____

Date of Birth: _____ SSN: _____ Phone: _____

Secondary Phone: _____ Email: _____ OK to ☐ Email

Primary Dr.: _____ Location: _____ Phone: _____

Pharmacy: _____ Location: _____ Phone: _____

Employer: _____ Occupation: _____

Best Method of Contact (Check all that apply): ☐ Call ☐ Text ☐ Email

Check all that apply:
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 ☐ Other: _____
Life Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Minor ☐ Student ☐ Other
Gender ID: ☐ Male ☐ Female ☐ Transgender ☐ Non-binary ☐ Other ☐ Decline to Answer

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 ID: _____

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

General Health History

Check all that apply:

Smoking: ☐ Yes ☐ No Chewing Tobacco: ☐ Yes ☐ No 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 any prescribed medication: _____

Permission to Disclose Confidential Information

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

Name	Relationship	Phone
_____	_____	
_____	_____	
_____	_____	
_____	_____	
_____	_____	

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