PLETT
FAMILY OPTOMETRY

WELCOME BACK QUESTIONNAIRE

Date: _____

Patient Information

Last Name: _____ First Name: _____ MI:_____ Sex: M F

Preferred Name: _____ SS#: _____/_____/_____ Birth Date: _____/_____/_____

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

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____ Occupation: _____ Employer/School: _____

Vision Insurance: _____ Medical Insurance: _____

Account Responsible: _____ SS#: _____/_____/_____ Birth Date: _____/_____/_____

Medical & Ocular History

Reason for today's visit: ☐ new glasses ☐ contact lenses ☐ dry eyes ☐ diabetic exam ☐ LASIK ☐ failed vision screening
☐ other _____

Ocular health changes: ☐ No ☐ Yes _____
Medical health changes: ☐ No ☐ Yes _____
Medication changes: ☐ No ☐ Yes _____
Medication allergies: ☐ No ☐ Yes _____
Pregnant or nursing: ☐ No ☐ Yes _____

Practice Polices

If you are using vision and/or medical insurance coverage for today's visit: I hereby authorize Plett Family Optometry to retrieve or exchange any information necessary to process my insurance claim. I will receive services with the understanding in the event that such coverage is denied, I will be held financially responsible. All deductibles, co-pays, non-covered services, and payment for materials are due on the date of service. Insurance information is required at the time of service. By signing below, you acknowledge that you have read and agreed to this statement.

Contact Lens Evaluation Fees: If you have insurance, your exam co-pay is for the comprehensive exam only. Wearing contact lenses are consider an elective form of vision correction, therefore the contact lens evaluation is not covered and you are responsible in full for this charge. Some insurance plans do allow a certain reimbursement for contact lenses in lieu of glasses. By signing below, you acknowledge that you understand there is an additional fee associated with the contact lens exam whether you are a current contact lens wearer or new to contact lenses.

Returned Check Fee: All returned checks will incur a $35.00 processing fee.

Notice of Privacy Practices: I (name printed above) have been presented with the Notice of Privacy Policy (HIPAA) of Plett Family Optometry and have been offered a copy of such policy for my records.

Patient Signature (parent/guardian if minor)	Doctor Signature Date