Welcome To *Enhance* Eye Care

PATIENT INFORMATION

Today's Date: _____ Nickname: _____

Last Name: _____ First Name: _____ MI: _____

Address: _____

City: _____ State: _____ Zip: _____

Home: (_____) _____Work: (_____)_____Cell: (_____)_____

Email Address: _____

Date of Birth _____ Age: _____ Soc Sec #: _____

Employer: _____ Occupation: _____

In Case of Emergency call: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Whom may we thank for referring you to us? _____

Date of last eye exam: _____ Dr./Location: _____

Date of last physical exam: _____ Dr./Location:_____

INSURANCE INFORMATION (**PLEASE GIVE CARD TO RECEPTIONIST** OR fill out if Insurance card not present)

Medical Insurance Company: _____ ID No: _____

Vision Insurance Company: _____ ID No: _____

Name of Insured Party: _____ **SS#** _____

Insured Date of Birth: _____ **Insured Employer**: _____

NOTICE OF PRIVACY PRACTICES

1. This notice describes how medical information about you may be issued and disclosed and how you can get access to this information. Please read it carefully.
2. Enhance Eye Care may use and disclose your health information with certain limits and protections for purposes of treatment, payment and heath care operations of this office.
3. Appointment Reminder: we may use your health information to provide you with appointment reminders via mail, phone or email.
4. Your Rights: you have the right to look at or get a copy of your health information that we use to make decision about you. You may limit disclosure to family members, other relatives, caregivers, or close personal friends.
5. Our Legal duty: Enhance Eye Care is hereby required by law to maintain the privacy of your protected health information. We are required to abide by the terms of this notice as it is currently stated, and reserve the right to change this notice at any time in compliance with and as allowed by law. The policies in any new notice will be posted and made available in our office.
6. Complaints: If you have a complaint regarding the way your protected health information was handled, you may submit it to the name, address, fax or email from the detailed explanation of the HIPPA form at your request. You can also send it to the U.S. Department of Health and Human Services, Office for Civil Rights.

Signature: _____ Date: _____

Thank You!

"We ***Enhance*** lives through **Eye Care**."