HOMETOWN
EYE CARE

Welcome back to our office.

Please update your information to the best of your ability.

Reason for Visit:			
Name: (First, Middle, Last)		Preferred Name:	
Date of Birth:			Birth Gender: ☐ M ☐ F
Mailing Address: (City State Zip Code)			
Home Phone:	Cell Phone:	Work Phone:	Email:
May we leave a message? ☐ YES ☐ NO			
Occupation & Employer:			
If patient is a child, Parent/Guardians Name:			
Primary Care Physician:			
Any New Medications? ☐ NO | ☐ YES Please List:			
Any New Allergies? ☐ NO | ☐ YES Please List:			

HIPAA AUTHORIZATION

I acknowledge that I have the right to authorize access and disclosure of my Protected Health Information (PHI) to anyone of my choosing for billing, condition, treatment and prognosis and herby authorize and request Hometown Eye Care, PLLC to release my information to:

Name	Relationship	Telephone
Name	Relationship	Telephone

I understand that I am entitled to a copy of Hometown Eye Care, PLLC's Notice of Privacy Practices. I can access a copy of the Notice of Privacy Practices and Insurance ABN at HometowneyecareNH.com or from the office directly. I understand that I have the right to revoke this authorization in writing at any time. **INTITAL:** _____

I hereby authorize Hometown Hometown Eye Care, PLLC to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the physician(s) all payment for medical services rendered to my dependednt or myself. I understand that I am responsible for any amount not covered by my insurance. **INTITAL:** _____

PAYMENT POLICY

Payment for professional services is expected when services are rendered. A deposit is required on all orders, and the balance is due to be paid upon delivery of any eyewear or contact lenses. **INTITAL:** _____

Print Patient Name:	
Signature (Patient or Representative):	Date:

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