I acknowledge that I have been informed of the Notice of Privacy Practices of Dr. Zane Lawhorn, OD and Dr. Scott Carpenter, OD. I give these doctors permissions to submit an insurance claim on my behalf and authorize the insurance benefits to be paid directly to the doctors. I understand that I am responsible for any non-covered services and agree to pay any outstanding balance in a timely manner. Please check the appropriate box:

Eyeglass prescription checks and contact lens follow-up appointments within 60 days of the initial exam are performed at no charge. After 60 days, there will be an appropriate follow-up fee, typically between $20.00 and $36.00.

Signature_____(Parent/Guardian if a minor)

BELOW TO BE COMPLETED BY OFFICE STAFF ONLY

_____

Exam and Tests_____

Amount to be Billed_____

Amount Paid by Patient_____

Payment

Date Insurance Billed_____ Paid in Full

Dr. Zane R. Lawhorn, OD **Dr. D. Scott Carpenter, OD**

Last Name_____First_____MI__
Address_____
City_____State_____Zip_____
Phone(Home)_____(Work)_____(Cell)_____
Social Sec #_____
Birthdate_____Age_____ Gender ☐Male ☐Female

Payment: ☐Cash/Check/Credit ☐Medicaid ☐Medicare ☐CHIPS ☐VSP
☐Superior Vision ☐PEIA ☐BCBS ☐Other_____

Have you experienced any of the following symptoms during the last 90 days:

☐Blurred Vision ☐Itching ☐Redness ☐Eye pain

☐Flashes/Floaters ☐Dryness ☐Watering ☐Tired Eyes

Have you ever had any eye surgery? **Yes**/**No** Explain_____
Any eye injuries? **Yes**/**No** Explain_____

Do you currently have any health problems in the following body areas?

☐Vascular (Blood pressure, cholesterol) ☐Ear/nose/throat (Sinus, allergies)
☐Neurological (MS, migraine, stroke) ☐Skin (rash, eczema)
☐Muscle/Joint (arthritis, fibromyalgia) ☐Respiratory (Asthma, COPD)
☐Psychiatric (Depression, anxiety) ☐Endocrine (Diabetes, Thyroid)
☐Genitourinary (kidney, bladder) ☐Hematologic (Anemia)
☐Gastrointestinal (ulcer, acid reflux) ☐Immune (Lupus, Sjögrens)
☐Constitutional (fever, weight loss/gain) ☐Sarcoidosis ☐Cancer
Other _____
List all medications you are taking_____
_____
_____
Are you allergic to any medicines? **Yes**/**No** Please list_____
_____
Do you have any family members with the following? (Explain Who):
☐Glaucoma_____ ☐Blindness_____
☐Macular Degeneration_____ ☐Cataract_____
☐Lazy Eye_____ ☐Diabetes_____
Occupation/grade_____Do you drive? ☐Yes ☐No
Hobbies_____Do you use: ☐Tobacco ☐Alcohol
After reviewing the handout about our Digital Retinal Imaging procedure, do you wish to have these photos taken: ☐Yes ☐No
Initials _____

Please read and sign the back page