I acknowledge that I have been informed of the Notice of Privacy Practices of Dr Zane Lawhorn, OD, Dr Scott Carpenter, OD, and Dr Brent Cole, OD. I give these doctors permission 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:

☐ Yes, I would like a paper copy of the Notice of Privacy Practices
☐ No, I do NOT want a paper copy of the Notice of Privacy Practices

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 COPLETED BY OFFICE STAFF ONLY

Exam and Tests_____
Amount to be Billed _____
Amount Paid by Patient _____
Payment ☐ Cash ☐ Check ☐ Visa / MC / Disc
Date Insurance Billed _____ ☐ Paid In Full

Zane Lawhorn, OD Scott Carpenter, OD Brent Cole, OD

Last Name_____First_____MI____
Address_____
City_____State_____ Zip_____
Phone (Home)_____(Work)_____
(Cell)_____Social Sec #_____
Birthdate_____ Age_____ Gender: ☐ Male ☐ Female
Email_____ Medical Doctor_____

Payment: ☐ Cash/check/credit ☐ Medicaid ☐ Medicare ☐ CHIPS ☐ VSP
☐ Superior Vision ☐ PEIA ☐ BCBS ☐ Other_____

When it comes to your eyes, do you experience any of the following:
☐ 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)
☐ 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_____
☐ Diabetes_____ Pharmacy of Choice_____

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
Do you want to have the new Diabetic Glucose Control test? ☐ Yes ☐ No

Initials_____ *Please read and sign the last page**