Buck Vision Care
Michael Buck, OD

Name:_____ Date of Birth:_____ Gender: _____

Address:_____City/State: _____ Zip:_____

Home PH:_____Cell PH:_____ Work PH: _____

Email Address: _____ Occupation: _____

Reason for visit today:_____Last exam date: _____

Do you currently wear contacts? Yes____ No____ Do you want to wear contacts? Yes____ No____

What brand of contacts do you wear and what solution? _____

Personal Medical/Vision History

Diabetes High Blood Pressure Heart Disease Thyroid Disease

Cataracts Glaucoma Eye Surgery Headaches Smoking High Cholesterol

Other medical problems: (please list) _____

Allergies to medications: _____Previous Surgeries:_____

List ALL current medications: _____

Family Medical/Vision History

Medical/Ocular History: _____

Insurance Information

Insurance name: _____ Member ID number: _____

Subscriber Name: _____Date of Birth: _____ SSN:_____

Payment type: (circle one) Cash Credit Card Debit Card Insurance

Financial Policy/Agreement

Payment of deductible, co-payment, and any uncovered services are due at the time of service. For minor children, whichever parent brings child in for services will be responsible for the bill/co-payment.

Non-insured patients are expected to pay in full at time of services.

HIPAA

I understand this office is HIPAA compliant and acknowledge that the HIPAA polices are posted and available to read.

Name of Authorized Person(s): **Relationship to Patient:**

_____ _____

Signature of Patient:_____ **Date:**_____