Welcome to Dr. Howard McFarland's Office

This information will allow us to begin the process that ensures your eye health and vision remain at their best, and that your health and lifestyle needs are met. Thank you for your help.

336-273-8291 office 336-273-2078 fax

Your Name ____
Last First Middle Nickname or Preferred

Your Address ____
Street or P.O. Box City State Zip

Your Date of Birth _____/_____/_____ Height_____ Weight______ SS# _____-____-_____ e-mail ________________________

Phone numbers cell (____) _____-________ home (___) ______-__________ work (___) _____-________ ☐ ok to text message?

Your Employer ______________________ Your Family Doctor ______________________

Your Preferred Pharmacy ______________________ Emergency contact______________________

If married, name of spouse ______________________ Spouse employed by ______________________

If under 18, parent or guardian's name ______________________Are you a full time student?_________

Relation to patient ______________ Phone ______-__________ Employer ______________________

Reason for your visit? ______________________Whom may we thank for referring you? ______________________

Have you ever worn contacts? ______________________Are you interested in contacts?______________________

How will you be paying today? ☐ Full payment by cash, check, debit or credit card ☐ Vision Care insurance or Care Credit

"I request that payment of benefits be made to me or the doctor for any services provided. I also authorize any holder of medical information about me to release to the carrier and its agents any information needed to determine these benefits or the benefits payable for related services."

"I understand that any services not covered by insurance and co-pays are due at time of service."

"I also acknowledge that I have had an opportunity to receive a copy of the Privacy Practices and Policies of this practice."

McFarland
OPTOMETRY

____
signature date

Optional…

Your occupation and lifestyle play the most important roles in determining your visual requirements.

How do you use your eyes at work? ____

What hobbies or activities do you enjoy? ____

What special vision needs or problems do you have? (glare, night vision, etc.) ______________________

Some ethnic groups are more at risk for eye disease.

Race? ___________Ethnicity? ☐Hispanic ☐Non Hispanic ☐Decline to provide Preferred language?_______________________
Gender? ☐ male ☐ female

PERMISSION TO DISCUSS PHI

***Patient Name:*____________________________________ *Date of Birth:*___________________**

***Account Number:*____**

If you would like our physicians and staff to discuss your personal health information with someone other than yourself, please list names below.

NAME	***RELATIONSHIP***
___________________________________	________________________
___________________________________	________________________
___________________________________	________________________
___________________________________	________________________
___________________________________	________________________

McFarland
OPTOMETRY

____
Signature of patient, parent, or guardian

____
Date

Permission to leave detailed message of pathology or test results on:

***Home phone*_____________________ *signature*_________________________**
***Cell phone** ______________________ **signature**_________________________*

In order to obtain information by telephone, anyone other than the patient must share the patient identifier with the staff.

***Patient Identifier:*_________________________**