

Canby Eyecare  
Ashley K McFerron OD  
364 N Ivy St  
Canby OR 97013  
503-266-4847 ph  
503-266-1106 fx

### PATIENT INFORMATION

Name _____	M / F _____	Birthdate _____	SSN _____		
Marital status (check one):	Single _____	Married _____	Divorced _____	Separated _____	Widow _____
Address _____	City/State/Zip _____				
Home Phone _____	Cell Phone _____	OK to Text? Y / N _____			
E-mail _____	Preferred Method of Communication	<input type="checkbox"/> Phone	<input type="checkbox"/> Text	<input type="checkbox"/> Email	
Employer Name _____	Work Phone _____				
Preferred Language _____	Race _____	Ethnicity _____			
Spouse Name _____	Birthdate _____	SSN _____			
Spouse Employer _____	Spouse Phone _____				

**If someone other than the PATIENT is responsible for payment, complete the following:**

Name of the responsible party \_\_\_\_\_ Address \_\_\_\_\_  
Relationship to patient \_\_\_\_\_ SSN \_\_\_\_\_ Home Phone \_\_\_\_\_  
Employer \_\_\_\_\_ Birthdate \_\_\_\_\_ Work Phone \_\_\_\_\_

**How do you intend to pay?** Cash \_\_\_\_\_ Check \_\_\_\_\_ Credit Card \_\_\_\_\_ Insurance \_\_\_\_\_ Care Credit \_\_\_\_\_ Other \_\_\_\_\_

**In case of EMERGENCY please contact:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

**Ok to release information to** \_\_\_\_\_

**How did you hear about our office?** \_\_\_\_\_

I understand that responsibility for payment of optical services provided at Canby Eyecare for myself or my dependents is mine, due and payable at the time services are rendered. I acknowledge that I am financially responsible for all charges. I agree to pay a 1.5% per month finance charge on all accounts 60 days, with a minimum fee of \$1.50. Insufficient returned checks charge \$25.00. I will give 24 hours notice if I am unable to keep an appointment.

Dilation of your eyes is necessary for Dr. McFerron to better see your retina. However, dilation can cause blurred vision and/or glare for many patients for several hours. Canby Eyecare has temporary sun protection for your use following dilation. These are available at no charge in the exam rooms as well as at the front desk. If one of our employees has not given you a pair, please ask for some. While these glasses help, Canby Eyecare recommends that you do not drive for the first few hours following dilation due to the blurred vision and glare. You may not be safe operating heavy equipment or hand tools. We will be happy to let you use our phone to call someone to pick you up or you may stay until the dilation effects have worn down. You may leave your car in our lot as long as necessary or even over night. Please do not do anything that would endanger yourself or others. You may return for this dilation on another day if it would be better for you.

Patient or Responsible Party Signature \_\_\_\_\_ Date \_\_\_\_\_

I authorize representatives of Canby Eyecare to leave voice mail messages for any necessary communications. \_\_\_\_\_ Date \_\_\_\_\_

I have received a copy of the Canby Eyecare Privacy Practice. Signature \_\_\_\_\_ Date \_\_\_\_\_

Update (Initial and Date) \_\_\_\_\_ Update (Initial and Date) \_\_\_\_\_ Update (Initial and Date) \_\_\_\_\_