PATIENT INFORMATION

Today's Date:_____ Date of last eye exam:_____

Patient Name:_____Date of Birth:_____

Address (City/State/Zip):_____

Phone Number: _____ Email:_____

Emergency Contact:_____ **Phone Number:**_____

Primary Physician:_____

Physician Phone Number:_____ Physician Location:_____

Whom may we thank for referring you?_____

Medical History

If you answer YES to any of the following questions, please use the space provided to explain.

Do you have any allergies to medication? [ ] N [ ] Y_____

List any medications you take (including oral contraceptives, aspirin, over-the-counter medications and home remedies):_____

_____

List all major injuries, surgeries, and/or hospitalizations you have had:

_____

Are you pregnant or nursing? [ ] N [ ] Y

Do you wear glasses? [ ] N [ ] Y If so, how old is your present pair of lenses?_____

Do you wear contact lenses? [ ] N [ ] Y If so, how old is your present pair of lenses?_____

Type of contact lenses? [ ] Rigid [ ] Soft [ ] Extended Wear [ ] Other:_____

Are they comfortable? [ ] N [ ] Y Brand:_____

Family History

Please circle the condition(s) and notate any family history (parents, grandparents, siblings, children) for the following:

[ ] Blindness / Cataracts / Crossed Eyes _____

[ ] Glaucoma / Macular Degeneration _____

[ ] Arthritis _____

[ ] Retinal Detachment / Disease _____

[ ] Cancer _____

[ ] Diabetes _____

[ ] Heart Disease / High Blood Pressure _____

[ ] Kidney Disease_____

[ ] Lupus_____

[ ] Thyroid Disease _____

[ ] Other_____

Social History

This information is kept confidential. However, you may discuss this portion directly with your doctor, if you would prefer.

Do you drive? [ ] N [ ] Y If so, do you ever experience visual difficulty when driving? [ ] N [ ] Y

Do you use tobacco products? [ ] N [ ]Y Amount / Type _____

Do you use alcohol? [ ] N [ ] Y Amount / Type _____

Do you use illegal drugs? [ ] N [ ] Y Amount / Type _____

Have you ever been infected with: [ ] Chlamydia [ ] Gonorrhea [ ] Hepatitis [ ] HIV [ ] Syphilis

REVIEW OF BODY SYSTEMS

Do you currently have, or have you ever had any problems in the following areas:

Condition	Yes	No	Explanation / Medications
Constitutional (fever, weight loss / gain)			
Integumentary (skin)			
Neurological (headaches, migraine, seizures)			
Eyes (loss of vision, blurred vision, double vision, dryness, itching, excess tearing, styes, flashes or floaters, infections, light sensitivity)			
Ears / Nose / Throat (allergies, congestion, runny nose, chronic cough, dry throat, dry mouth)			
Respiratory (asthma, chronic bronchitis, emphysema)			
Vascular / Cardiovascular (diabetes, heart pain, high blood pressure, vascular disease)			
Gastrointestinal (constipation, IBS, crohn's, colitis)			
Genitourinary (genitals, kidneys, bladder)			
Bones / Joints / Muscles (Rheumatoid Arthritis, muscle or joint pain)			
Lymphatic / Hematologic (anemia or bleeding problems)			
Endocrine (diabetes, thyroid)			
Allergic / Immunologic			
Psychiatric			
Other			

Patient / Guardian Signature:_____ Date:_____

Doctor Signature:_____ Date:_____

AGREEMENT OF RESPONSIBILITY AND CONSENT TO TREAT

Terms of Service

- I understand that during the course of my examination, diagnosis may arise which may require additional testing and/or constitute a medical exam. These services will be billed to the medical insurance I provide.
- I understand that professional services are rendered to the patient and the patient is responsible for charges incurred for these services. I understand that I am financially responsible for charges not covered by my insurance company.
- Payment for annual deductibles, co-pays and co-insurances may be mailed in the form of a statement. I further understand that I am responsible for all collections and fees which may occur on any unpaid balance.
- I am responsible for presenting complete and accurate insurance information prior to receiving services. If I am unable to do so, I acknowledge that I will be responsible to pay for the visit and submit for reimbursement to my insurance company on my own.

Consent to Treat

- I voluntarily consent to such care and treatment as prescribed by the physician as is necessary in his/her medical judgment.

Release of Information/Assignment of Benefits

I authorize use of this form on all my insurance submissions and authorize the release of information needed to process a claim to all of my insurance companies. I permit a copy of this authorization to be used in place of the original. I understand the provider does not accept responsibility for collecting my insurance claims or for negotiating a settlement on disputed claims. I assign all rights and claims for reimbursement of expenses allowable under my insurance plan and authorize payment directly to the provider for services rendered. My signature acts as a “signature on file” for claims processing and release of information to my insurance carrier.

*****I understand I will receive a monthly statement for any balance due by me. I agree to pay any unpaid balance due and owing on my account.*****

Printed Name:_____ Date:_____

Patient/Guardian Signature:_____

OFFICE POLICIES / CONSENTS

Notice of HIPAA Privacy Practices

I authorize that I have been presented with Chad J. Jackson O.D. PLLC Notice of Privacy Practices and have been offered a copy to keep with my records. I understand the staff of Bella Vista Family Eye Care will keep all of my vision/medical records confidential and that my information will not be shared with any other non covered entities, unless I give prior authorization.

Patient/Guardian Signature:_____

Date:_____

HIPAA APPROVED ENTITIES

It is the policy of Bella Vista Family Eye Care to communicate with our patients via phone, email, text or regular mail regarding appointments, exam results, payments, orders etc. In order to ensure that you receive the information in a timely fashion we may provide such information to people of your choosing. Please list the approved entities below. You may change this authorization at any time.

Name:_____

Relationship:_____

Name:_____

Relationship:_____

Patient/Guardian Signature:_____

Date:_____