Today's Date: ______________________

Patient Name: ____ DOB: _________________ M/F

Address: ____ Apt #: ________________

City: ___________________________________ State: _____________________ Zip: __________________

Home Phone: ______________________ Cell: ______________________ Work: _____________________

Employer: ____ Occupation: _____________________

Marital Status: _______________________ Race: ___________________ Ethnicity: ___________________

Email: ____

How did you hear about our office? If referred, who may we thank for the referral?

____

INSURANCE INFORMATION

Primary Medical Insurance: ____

ID Number: ____ Group Number: ________________

Subscriber Name: ____ DOB: ___________________ M/F

Relationship to patient: _______________________________________ SSN: _________________________

Do you have an FSA (flexible spending account) or HSA (health spending account)? Yes NO

Vision Insurance: ____

ID Number: ____ Group Number: ________________

Subscriber Name: ____ DOB: ___________________ M/F

Relationship to patient: _______________________________________ SSN: _________________________

MEDICAL HISTORY

Are you currently being treated for: __ **No Medical Conditions**

- ☐ Allergies
- ☐ Dry Eye
- ☐ Corneal Problems
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Retinal Disease/Detachment
- ☐ Corneal Problems
- ☐ Macular Degeneration
- ☐ Cancer ___________________________

- ☐ Thyroid Disease
- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Kidney Disease
- ☐ Elevated Cholesterol
- ☐ Heart Disease
- ☐ Auto-immune Disease
- ☐ Pregnancy

If you are currently being monitored for the above health issues, please provide information requested below in order to coordinate your care:

Physician name: ___________________________________Phone: _________________________

Are you currently taking any medications? Please list prescribed and over the counter meds.

___

Are you using any eye drops? ____

Are you **allergic** to any medications? ____

Have you had any major surgeries? ____

Please indicate which you have tested positive for: ___ HIV ___ AIDS ___Hepatitis ___STD

Smoking/Vape: ___ No ___ Socially ___ Average Use ___ Heavy Use

Alcohol Use: ___ No ___ Socially ___ 1-2 drinks per day ___ Alcohol dependence

Narcotic Use: ___ No ___ Recreational Use ___ Chemical dependence

FAMILY HISTORY

Please list relationship and maternal/paternal relation:

- ☐ Cancer __________________________
- ☐ Diabetes _________________________
- ☐ Retinal Detachment ________________
- ☐ Macular Degeneration______________

- ☐ Blindness ______________________
- ☐ Hypertension ___________________
- ☐ Heart Disease ___________________
- ☐ Glaucoma ______________________

EYE HEALTH HISTORY

Last eye exam date? ___________How old are your current glasses? _____contacts? _____

What brings you in today? Check all that apply:

☐ Blurred Vision	☐ Light Sensitivity	☐ Burning	☐ Red Eye	☐ Floaters
☐ Glare	☐ Eye Turn	☐ Itching	☐ Trauma	☐ Bump on Lid
☐ Allergies	☐ Double Vision	☐ Pain	☐ Flashes	☐ Foreign Body

Are there other concerns you would like to discuss today?

____

Are you planning on updating your eye wear/contacts today? ☐ Yes ☐ No

Are you interested in LASIK? ☐ Yes ☐ No

WELLNESS EXAM

At Bright Side Eye Care, Optomap imaging is **required** and performed annually on all patients:

- *Optomap*: Entails taking a digital image of the eye utilizing a retinal camera, for the purpose of medical documentation. Dilation is not required. This enables a wide view of the inside of the eye to examine for diseases such as: high blood pressure, high cholesterol, diabetes, glaucoma, macular degeneration, retinal detachments, and tumors – to name a few. The images link with your medical record and can be used for comparison during future eye exams. There are no side effects or extra wait time associated with this test. (**$25 fee)**

Additional Wellness Testing:

- *Pupil Dilation*: Entails enlarging the pupils through the use of medicated eye drops to enable the doctor to have a more thorough view of the retina. This test is strongly recommended, especially for children. Side effects are blurry near vision and light sensitivity, which may last up to 3-4 hours; driving is seldom effected.

  Do you want to have your eyes dilated? (No fee) ʊ YES ʊ NO

- *OCT*: Entails taking a high resolution, cross-sectional 3D image of the retina. This non-invasive technique allows detection of early disease processes.

  Do you want OCT performed? ($25 fee) ʊ YES ʊ NO

CONSENT NOTICE

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) I understand that I have certain rights to privacy. By signing this form, you acknowledge that you have reviewed our Notice of Privacy Practices and disclosures of protected health information for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent.

CONSENT TO DISCLOSE MY GENERAL HEALTH INFORMATION

With my signature below, I hereby authorize Bright Side Eye Care to disclose my medical information so that the practice may provide treatment, seek payment from third parties for such treatment, and generally carry on the health care operations of the practice (e.g., quality assurance). I also authorize the disclosure of my medical information to insurers and providers outside of this practice when necessary for purposes of my treatment, payment for such treatment, and for their health care operations.

60 DAY PRESCRIPTION GUARANTEE

There are many factors that can affect your visual acuity. Our doctor honors a guarantee on your glasses and contact lens prescriptions for up to 60 days from your initial examination. Fees are separate for your comprehensive exam for glasses and contact lens evaluation. Additional visits after 60 days from the examination date will be subject to our usual and customary fee of $45 per visit. The additional visits are not covered by insurance.

Due to the customized nature of spectacle eye wear, all sales on glasses are final and non-refundable.

NOTICE OF FINANCIAL POLICY

Payment for service is due, in full, at the time of service. All outstanding accounts turned over to a collection agency will be assessed an additional charge of $50.

I understand and agree to the consent notices and financial policy outlined above. Our doctor is therapeutically licensed to perform an ocular medical health evaluation at every exam. Medical findings may be billed through your medical insurance policy. Furthermore, I understand that if my insurance eligibility cannot be verified or if I do not obtain the proper physician referral, I will be financially responsible for payment of all charges incurred for services received at Bright Side Eye Care.

Patient/Guardian Name (Print): ____ Date: ______________

Patient/Guardian Signature: __________________________________ Relationship: ________________