PREMIER FAMILY VISION

N.P. Bhadra, OD & Associates, PC

LAST
NAME_________________________FIRST_____________________MI_______DATE______________

ADDRESS____CITY&ZIP______________________

SS(last 4#s)____________________BIRTHDATE_____________________AGE__________ M / F

EMPLOYER ____________________VISION &MEDICAL INSURANCES________________________

HOME PHONE__________________________________WORK PHONE_________________________

CELL PHONE ________________________________E-MAIL _________________________________

24-48 HR PRIOR NOTICE IS REQUIRED FOR ANY INSURANCE VERIFICATION PRIOR TO SERVICES RENDERED

LAST EXAM_______________________FROM DR.____
HOBBIES ____
REFERRED BY: PATIENT ___________________________ INSURANCE_________

REASON(S) FOR TODAY'S VISIT:

____GENERAL CHECK UP ____EYE PAIN ____POOR NIGHT VISION
____LOST/BROKEN GLASSES ____SEEING SPOTS ____WANT CONTACTS
____BLURRED DISTANCE VISION ____EYES BURN/ITCH ____PROBLEM W/CONTACTS
____BLURRED NEAR VISION ____HEADACHES ____GLARE
____OTHER (SPECIFY) ____

HAVE YOU EVER WORN GLASSES? Y / N IF SO, FOR: DISTANCE/NEAR/CONSTANT
DO YOU WEAR CONTACTS? Y / N BRAND/TYPE _______________________________________

DO YOU TAKE ANY MEDICATIONS? Y / N PLEASE LIST:_____________________________
____DIABETIC MEDICINE ____BLOOD PRESSURE MED ____STEROIDS
____ANTIHISTAMINES OTHER____
ARE YOU ALLERGIC TO ANY MEDICATION? ____NO ____YES: LIST_________________
HAVE YOU BEEN SEEN IN THIS OFFICE BEFORE? Yes No
DO YOU OR ANY FAMILY MEMBERS HAVE: IF SO, WHO?
_____HIGH BLOOD PRESSURE _____DIABETES ____HEART DISEASE
_____ARTHRITIS _____MACULAR DEGENERATION
_____GLAUCOMA _____CATARACTS ____SEASONAL ALLERGIES
_____COLOR VISION PROBLEMS _____DOUBLE VISION (WHEN:_____________________)
_____EYE INFECTION/EYE INJURY/EYE SURGERY (TYPE: _________________________________)

PLEASE READ AND INITIAL BELOW:

WE MAY NEED TO INSTILL DROPS TO EXAMINE THE EYES. THESE DILATING DROPS MAY CAUSE BLURRED VISION AND SENSITIVITY TO LIGHT.
_____YES, I GIVE PERMISSION FOR DIAGNOSTIC DROPS TO BE USED IN MY EYES.
_____NO, I DO NOT GIVE PERMISSION FOR DIAGNOSTIC DROPS TO BE USED IN MY EYES.

_____YES, I DO GIVE AUTHORIZATION FOR EXAMINATION AND EVALUATION.
_____YES, I DO ACKNOWLEDGE I HAVE BEEN GIVEN ACCESS TO THE NOTICE OF PRIVACY
_____YES, I DO GIVE AUTHORIZATION FOR PREMIER FAMILY VISION TO FILE FOR ANY INSURANCE BENEFITS.
_____YES, I DO UNDERSTAND, IN THE EVENT MY INSURANCE DOES NOT PAY, I AM RESPONSIBLE FOR THE OUTSTANDING CHARGES.
____ ALL PROFESSIONAL FEES ARE NON-REFUNDABLE.

PATIENT/ AUTHORIZED AGENT'S SIGNATURE:____