WELCOME TO BELLAIRE OPTOMETRY

Today's date _____

Last name _____ First name _____ MI _____ ☐ Male

Address _____ ☐ Female

City _____ State _____ Zip _____ ☐ Single

Date of birth _____ Age _____ Height _____ Weight _____ SSN _____ ☐ Married

Email _____ Cell phone _____

Work phone _____ Home phone _____

Occupation _____ Employer _____

Date of last eye exam _____ Last eye doctor _____

Emergency contact name _____ Phone _____ Relation _____

Please check all benefits you currently have:

☐ Vision insurance ☐ Health insurance ☐ Medicaid ☐ Medicare ☐ CHIP

Name of insured primary _____ Relationship to patient _____

His/her date of birth _____ His/her SSN _____

Insurance company _____ Patient ID no. _____

ASSIGNMENT OF BENEFITS / RELEASE OF INSURANCE

I hereby assign all insurance benefits, Medicare and/or Medicaid, to *Bellaire Optometry* for services rendered. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges not paid by my insurance plan. In addition, I authorize *Bellaire Optometry* to release all information that may be found in my records to consulting physicians for continuing medical care and/or to any third party in order to process my insurance claims.

Signature _____ Date _____

OPTOMAP

Because your eyes' health is our utmost concern, our doctors highly recommend that an Optomap (retinal digital image) be done annually for every patient. Retinal problems such as glaucoma, retinal detachment, holes, tears, lesions, and diabetic retinopathy can now be seen without dilation for most patients. Early detection is crucial.

Optomap fee is $35 (usually not covered by insurance).

☐ Yes to Optomap ☐ No to Optomap

Signature _____ Date _____

DILATION

While many eye conditions can be seen with Optomap, others can only be detected with dilation. We also recommend dilation for young children, for first eye exam, and for adults who have diabetes, high blood pressure, symptoms of flashes and floaters, or family history of eye diseases. Dilation causes temporary light sensitivity and blurred near vision for 2-4 hours.

There is no extra charge for dilation.

☐ Yes to dilation ☐ No to dilation

Signature _____ Date _____

MEDICAL HISTORY

Do you have any allergies to medication? □ Y □ N If yes, please explain _____

List medications you are taking (including eye drops, oral contraceptives, over-the-counter medications):

_____

List all major injuries, surgeries, and hospitalizations you have had _____

Are you pregnant and/or nursing? □ Y □ N If yes, how many months? _____

Do you wear glasses and/or contacts? □ Y □ N If yes, how old is your current pair or lenses? _____

REVIEW OF SYSTEMS

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

Eyes (vision lost, blurred, double, distorted, burning, itching, tearing, irritated, pain, light sensitive, redness, mucous discharge, flashes, floaters, lazy eyes, crossed eyes, glaucoma, cataract, retinal detachment, macula degeneration)	□ Y □ N	Please explain:
Constitutional (fever, weight loss/gain)	□ Y □ N	
Ear/nose/mouth/throat (hearing loss, sinus problems, sore throat)	□ Y □ N	
Cardiovascular (high blood pressure, heart problems, chest pain)	□ Y □ N	
Respiratory (asthma, shortness of breath, wheezing, coughing)	□ Y □ N	
Gastrointestinal (heartburn, abdominal pain, diarrhea, vomiting)	□ Y □ N	
Genitourinary (genitals, kidney, bladder problems)	□ Y □ N	
Integumentary (skin rash, excessive dryness)	□ Y □ N	
Musculoskeletal (muscle aches, joint pain, swollen joints)	□ Y □ N	
Neurological (numbness, headaches, migraines, paralysis, seizures)	□ Y □ N	
Hematologic/Lymphatic (blood disorders, leukemia, anemia, bleeding problems)	□ Y □ N	
Allergic/Immunologic (hay fever, allergies, HIV/AIDS)	□ Y □ N	
Endocrine (thyroid problems, diabetes)	□ Y □ N	
Psychiatric (depression, anxiety)	□ Y □ N	
Other (cancer, high cholesterol, hepatitis)	□ Y □ N	

FAMILY & SOCIAL HISTORY

Do any of your immediate family have any of the above conditions? Please list:

Relationship _____ Conditions _____

Relationship _____ Conditions _____

Do you smoke? □ Y □ N If yes, how much a day? _____

Do you drink? □ Y □ N If yes, how much a day? _____

Do you or have you used illegal drugs? □ Y □ N If yes, which ones? _____

Have you ever had: □ Gonorrhea □ Hepatitis □ HIV □ Syphilis

HIPAA NOTICE OF PRIVACY PRACTICES

I am aware of the HIPAA Privacy Protection policy information and understand that this office complies with these policies.

Patient's Signature _____ Date _____

Reviewed by _____ Date _____