Welcome to *Bell Vision Optometry!*

Please take a few minutes to fill out your medical history.

Name: _____ Date of Birth: _____ Sex (M/F):____ Date:_____

If patient is a minor, full name of mother/father/guardian: _____

Address: _____

Phone (Cell): _____ (Home/Work): _____ SSN: _____

Last Eye Exam (date): _____ Last Medical Exam (date): _____

Name of Medical Ins.: _____ Medical Doctor (name): _____

What is your eye problem/complaint today? *Please describe this problem you are having as best as you can.*

_____

Patient Ocular/Medical History	Yes	No
Glaucoma		
Cataracts		
Macular Degeneration		
Eye Injury		
Retinal Disease		
Loss of Vision/ Blindness		
Eye Turn/ Strabismus		
Lazy Eye/ Amblyopia		
Eye Infection		
Dry Eye		
High Blood Pressure/Hypertension		
Diabetes		
Other Disease(s)/Prematurity		
Do you wear glasses?		
Do you wear contact lenses?		
If NO, would you like to?		
Have you ever had a surgery on your eyes?		
If YES, what surgery was it? Why did you have it performed?		

Family Ocular/ Medical History	Yes	No
Glaucoma		
Cataracts		
Macular Degeneration		
Eye Injury		
Retinal Disease		
Loss of Vision/ Blindness		
Eye Turn/ Strabismus		
Lazy Eye/ Amblyopia		
Eye Infection		
Dry Eye		
High Blood Pressure/Hypertension		
Diabetes		
Other Diseases (i.e. cancer)		

Social History	Yes	No
Do you smoke?		
If YES, do you smoke every day?		
If NO, have you smoked in the past?		
Do you use recreational drugs?		
Do you drink alcohol?		
Are you currently pregnant/nursing?		
What is your occupation?		
What are your hobbies?		
How many hours a day do you use a computer?		
What is your current height?		
What is your current weight?		

Patient Review of Health *Do you have or ever had problems in the following areas?*	Yes	No
Constitution (*Fever, weight gain/loss*)		
Cardiovascular/Vascular (*High Blood Pressure, Stroke*)		
Ears, Nose, Throat, Mouth (*Allergies, Sinus Congestion, Dryness*)		
Respiratory (*Asthma, Bronchitis, Emphysema*)		
Gastrointestinal (*Diarrhea, Constipation*)		
Genitourinary (*Genitals, Kidney, Bladder problems*)		
Musculoskeletal (*Arthritis, Joint/Muscle pain*)		
Integumentary (*Skin problems*)		
Neurological (*Headaches, Migraines, Seizures*)		
Psychiatric (*Mental/Emotional Problems*)		
Endocrine (*Thyroid, Diabetes*)		
Hematologic/ Lymphatic (*Anemia, Bleeding Proble*		
Allergic/Immunologic (*Allergy*)		
Cancer		

If YES, please explain:_____

_____

_____

_____

Medications: *List all medications that you currently taking. If you are unsure, please list what the medication is for:*

_____

_____

Allergies: *List any food or drug allergies & the associated types of reactions you have:*

_____

_____

Medical History reviewed by Optometrist (sign and date) _____

Emailing and Texting

The Privacy Rule allows covered healthcare providers to communicate electronically, such as through email or text messages, with their patients, provided they apply reasonable safeguards when doing so. Please select and sign below which alternative mean(s) you allow Bell Vision Optometry to communicate with you:

- ☐ YES, I accept email and/or texting (and understand that charges may apply from my phone carrier) to receive updates and messages from Bell Vision Optometry. If so, please provide email and sign below.
  If yes, please select an option from below:
  - o BOTH Email and Texting
  - o ONLY Email
  - o ONLY Texting
- ☐ NO, I decline email and texting and prefer that Bell Vision call me on the number(s) listed above to receive updates and messages. You may decline to input your email but please sign below.

_____
Patient Email

_____ _____
Signature of patient Date

_____ _____
Signature of Parent/Legal Guardian (If patient is a minor) Date

Acknowledgment of Notice of Privacy Practices

I understand and acknowledge that in an attempt to protect the privacy of my identifiable health information, Bell Vision Optometry has established a *Notice of Privacy Practices.* This information details the use and disclosure of information contained in my personal medical records kept for the purposes of diagnosis, treatment, payment and healthcare operations. In accordance with HIPAA Regulations, a copy of Bell Vision Optometry's *Notice of Privacy Practices* has been made available to me while in the facility today. Should I choose to have a personal copy, one will be given to me at no charge.

_____ _____
Patient Signature (If not a minor) Date

_____ _____
Parent/Legal Guardian Signature (If patient is a minor) Date

Bell Vision Optometry

Financial Agreement and Consent to Treatment

The following contains important information concerning your financial responsibilities and your treatment at Bell Vision Optometry. Please read it carefully.

1. **FINANCIAL AGREEMENT:** I understand **payment for services is due in full at the time services are rendered.** Direct ship contact lenses must be paid in full at the time of order. Because services are based on medical necessity it is impossible for Bell Vision Optometry to provide a total cost prior to evaluation. I understand Bell Vision Optometry will bill my insurance as a courtesy, but this is not a guarantee that my insurance will pay for services rendered or materials provided. It is my responsibility to know my insurance benefits and coverage. **I am responsible for all copays, deductibles, and services or materials not covered by my insurance.** In the event that it becomes medically necessary for Bell Vision Optometry to enlist the services of a collection agency and/or legal assistance, I will be responsible for any allocation expenses and reasonable fees.

_____
Initial Here

2. **NON-COVERED SERVICES:** I understand that Bell Vision Optometry's agreements with health insurance plans (i.e. HMOs, PPOs) relates only to items and serves which are "covered" by the insurance plan. **I accept full financial responsibility for all items or serves, which are determined by my insurance not to be covered, including the refraction fee.**

_____
Initial Here

3. **MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to Bell Vision Optometry for services furnished me by Bell Vision Optometry. I authorize any holder of medical information about me to release to the center for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related serves. I understand my initials request that payment be made and authorizes release of medical information necessary to pay the claim. I also understand that I am responsible for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

_____
Initial Here

Authorization to Bill: I have read and understood the above information and agree to comply with these terms. I authorize my insurance company to make payment directly to Bell Vision Optometry for services and/or materials rendered. I authorize Bell Vision Optometry to release information about me or my dependents necessary to process any and all claims for reimbursement on my behalf.

Authorize to Treat: I also authorize Bell Vision Optometry, it's agents and employees, to furnish optometric care and services including but not limited to, diagnostic tests, examination and other medical and/or surgical procedures, which is deemed necessary in the course of my care.

_____	_____	_____
Patient Name (Print)	Patient or Parent/Guardian Signature	Date

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Information on Primary Card Holder

Primary Cardholder Name:_____ Relationship to patient:_____
Address:_____ Date of Birth:_____
City:_____ State: _____ Zip:_____
SSN:_____ Work Phone:_____
Insurance company:_____ ID #:_____
Group #:_____

Information on Secondary Card Holder (If secondary insurance available)

If same name and info as primary, please only fill insurance company, ID# and Group #

Secondary Cardholder Name:_____ Relationship to patient:_____
Address:_____ Date of Birth:_____
City:_____ State: _____ Zip:_____
SSN:_____ Work Phone:_____
Insurance company:_____ ID #:_____
Group #:_____