NAME _____ EMAIL _____

DATE OF BIRTH _____ AGE_____ PHONE _____

ADDRESS _____ CITY, STATE & ZIP: _____

FAMILY PHYSICIAN NAME _____

OFFICE LOCATION _____

CURRENTLY WEAR GLASSES? Y N

LAST EYE EXAM _____

CURRENT CONTACT LENS WEARER? Y N
IF YES, WHAT BRAND? _____
IF NO, ARE YOU INTERESTED IN TRYING CL? Y N

REASON FOR VISIT/PROBLEMS YOU ARE EXPERIENCING: _____

_____

Please circle all that apply to you:

Developmental Disabilities	ADD	Crohns	Thyroid
Cancer _____	Hypertension	Colitis	Herpes Zoster/Shingles
Dry Mouth	Heart Disease	Muscular Dystrophy	Herpes Simplex/Cold Sores
Hearing Loss	Asthma	Ankyslosing Spondylitis	Rosacea
Epilepsy	Sleep apnea	STD	Psoriasis
Migraines	Multiple Sclerosis	Kidney	High Cholesterol
Sjogren's Syndrome	Rheumatoid Arthritis	Diabetes: Type 1 Type 2	Pregnant Trimester: 1 2 3
Stroke/CVA			Nursing

Please list your current medications OR provide a list to our staff to copy.

Drug Name	*Taken how often?*	*Reason?*

Drug, Food, or Seasonal Allergies: Yes ____ No _____ If yes, please list _____

_____

OCULAR HISTORY: Mark all that apply.

Retinal Hole/Detachment	Eye Turn/Strabismus	Lazy Eye/Amblyopia
Eye Injury	Glaucoma Glaucoma Suspect	Keratoconus
Dry Eye	Cataract	Eye Surgery
Macular Degeneration	Other: _____	

FAMILY MEDICAL HISTORY: Mark all that apply to a close blood relative.

Glaucoma Who: _____ Retinal Detachment Who: _____

Thyroid Who:_____ Diabetes Who:_____ Macular Deg. Who: _____

Dry Eye Who: _____ Amblyopia/Lazy Eye Who: _____

SOCIAL HISTORY:

Alcohol Use: **Y**es **N**o If yes, #_____ drinks per day/ week/ month

Tobacco Use: **Y**es: some days ___everyday___ **N**ever **F**ormer

Type: cigarette/ cigar/ pipe/ smokeless Amount: _____ per day/ week

If former tobacco user, how many years ago did you quit? _____

I authorize Bright Family Eye Care LLC to use this authorization in place of my physical signature on submissions to my insurance carrier. I authorize assignment of payments directly to Bright Family Eye Care LLC when applicable. I understand that it is my responsibility to know the details of my individual insurance plan deductibles and co-pay/co-insurance amounts. I understand that although a procedure may be covered by my insurance I may have amounts out-of-pocket for co-pays and co-insurance or if I have not yet met my deductible. I understand I am ultimately responsible for my/my child's charges if unpaid or denied by insurance as my insurance is a contract between myself and my insurance company and not Bright Family Eye Care LLC or the provider.

I understand that the billing of insurance is determined by the reason for my visit as will as ultimate diagnosis. I understand that vision insurance (ie. Eyemed, VSP, Davis Vision, MedBen Vision, etc.) covers only routine/preventative eye examinations for purposes of vision correction and/or eye health screening. I understand that examinations for concerns such as diabetes, cataracts, glaucoma, eye pain, redness, "spots in vision", dry eye, blurry vision not due to the need for glasses/contacts, among other problem focused complaints are not addressed during a routine/preventative examination and any visit for those complaints will be considered a medical visit and will be billed through my medical insurance provider. I understand that, outside of urgent eye issues, I can request that my vision plan be used and may then return at a later date and time to address specific medical eye concerns with scheduled time for further testing and consultation with that visit billed to my medical plan.

Signed: _____ *Printed Name:* _____ *Date:* _____

Relationship to patient: _____

I have been given or offered a copy of this practice's notices of HIPAA privacy practices. *INITIAL* _____