BESSEMER
FAMILY EYE CARE

PATIENT INFORMATION

Dr. _____ Mr. _____ Mrs. _____ Ms. _____ Miss _____ Male/Female? _____

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Primary Phone: _____ □ Mobile □ Home □ Work

Email Address: _____

Communication Preference: □ Email □ Mail □ Phone

May we email or text you important messages? □ Yes □ No

Date of Birth: _____ Social Security #: _____

Place of Employment/School: _____ Occupation: _____

Spouse/Parent Name: _____

Spouse/Parent Phone #: _____

Demographic Information Requested by Federal Government

Race: □ American Indian or Alaska Native □ Asian □ Black or African American
□ Native Hawaiian or Pacific Islander □ White or Caucasian

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino

Preferred Language: □ English □ Spanish □ Other _____

Responsible Party Information

Person Responsible for Bill _____

Address: _____ Phone: _____

Medical Insurance: _____ Policy #:_____

Vision Insurance: _____ Policy #:_____

If the insured is other than patient, please provide the following:

Insured's Social Security #:_____ Date of Birth: _____

Insured's Employer: _____

Other Insurance Information: _____

Do you currently wear glasses?	Yes	No
Do you plan to update your glasses?	Yes	No
Do you currently wear contacts?	Yes	No
*Do you have backup glasses?	Yes	No
Do you have prescription sunglasses?	Yes	No
Are you interested in thinner lenses?	Yes	No
Are you interested in LASIK?	Yes	No
Do you work on a computer?	Yes	No

NEW PATIENTS ONLY:

Who may we thank for referring you to us?

_____

If not referred, how did you choose us?

_____

Patient Ocular and Medical History

Patient Name: _____ Male/Female: _____ Date: _____

Name of Primary Care Physician: _____ Other Doctor(s): _____
Last Eye Exam: Date: _____ Location: _____ Doctor: _____

Personal Medical History:

*Have **you** ever been diagnosed with:*

Glaucoma	Yes	No	Diabetes	Yes	No
Cataracts	Yes	No	Heart Disease	Yes	No
Retinal Detachment	Yes	No	High Blood Pressure	Yes	No
Eye Injury	Yes	No	High Cholesterol	Yes	No
"Lazy Eye"	Yes	No	Stroke	Yes	No
Diabetic Eye Disease	Yes	No	Cancer _____	Yes	No
Thyroid Eye Disease	Yes	No	Thyroid Disease	Yes	No
Macular Degeneration	Yes	No	Multiple Sclerosis	Yes	No
Other _____			HIV/AIDS	Yes	No
_____			Migraines	Yes	No
_____			Asthma/Emphysema (circle)	Yes	No

List all major **surgeries**, injuries, and/or hospitalizations you have had: _____
_____
List any **eye surgeries**: _____
List all **medications** (Prescription/Over the Counter): _____
_____
_____

Do you have any **allergies** to medications? Yes No If yes, list: _____
Do you have any **seasonal/food allergies**? Yes No If yes, list: _____
Are you **pregnant**? Yes No

Social History:

Do you use tobacco? Yes No Type: _____ Quantity: _____
Do you drink alcohol? Yes No Type: _____ Quantity: _____
Do you drive? Yes No
Do you use any other drugs? Yes No Type: _____ Quantity: _____
Circle if you have been exposed to or infected with: Gonorrhea Syphilis HIV Hepatitis

Family Medical History: Has anyone in your family had… (Please list relationship to you)

Macular Degeneration	Yes	No	_____
Glaucoma	Yes	No	_____
"Lazy Eye"	Yes	No	_____
Cataracts	Yes	No	_____
Diabetes	Yes	No	_____
High Blood Pressure	Yes	No	_____
Heart Disease	Yes	No	_____
Other _____	Yes	No	_____

(over)

Review of Systems:

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

Eyes				**Genitourinary**			
Poor vision	Yes	No	?	Burning on urination	Yes	No	?
Eye pain	Yes	No	?	Urinary frequency	Yes	No	?
Tearing	Yes	No	?	Incontinence	Yes	No	?
Redness	Yes	No	?	**Musculoskeletal**			
Jaw pain	Yes	No	?	Joint pains	Yes	No	?
Scalp tenderness	Yes	No	?	Stiffness	Yes	No	?
Transient vision losses	Yes	No	?	Arthritis	Yes	No	?
Loss of vision	Yes	No	?	**Integumentary**			
Constitutional/Symptom				Rash	Yes	No	?
Fever	Yes	No	?	Changing moles	Yes	No	?
Chills	Yes	No	?	**Neurological**			
Weight loss	Yes	No	?	Headache	Yes	No	?
Ear, Nose, Throat, Mouth				Seizure	Yes	No	?
Stuffy nose	Yes	No	?	Stroke	Yes	No	?
Ear ache	Yes	No	?	Paralysis	Yes	No	?
Cough	Yes	No	?	**Psychiatric**			
Cardiovascular				Anxiety	Yes	No	?
High blood pressure	Yes	No	?	Depression	Yes	No	?
Rapid heartbeat	Yes	No	?	Insomnia	Yes	No	?
Respiratory				**Endocrine**			
Congestion	Yes	No	?	Diabetes	Yes	No	?
Wheezing	Yes	No	?	Thyroid abnormalities	Yes	No	?
Shortness of breath	Yes	No	?	**Hematologic/Lymphatic**			
Gastrointestinal				Bleeding Disorders	Yes	No	?
Upset stomach	Yes	No	?	Anemia	Yes	No	?
Diarrhea	Yes	No	?	**Allergic/Immunologic**			
Constipation	Yes	No	?	Allergies/Hay Fever	Yes	No	?
				Hives	Yes	No	?

Please list any other health-related issues you have been diagnosed with not mentioned above: _____

_____

_____

Doctor's Notes:

Reviewed by:

Clinician: _____ Date: _____

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CONSENT FOR TREATMENT AND FINANCIAL AGREEMENT

Patient's Name: _____ Date: _____

I consent to treatment necessary or desirable to the care of the patient mentioned above, including but not restricted to, dilation drops, pharmaceutical agents, and/or minor surgical procedures that may be used by the Doctor of Optometry, his technicians or qualified designate.

Dilation of the eyes is necessary to obtain the best view of your retina, but can cause blurred vision and/or glare for several hours. We recommend that you do not drive for the first few hours following dilation. You may return for this dilation on another date, use our phone to call someone to pick you up, or stay until the dilation effects have worn off. **I understand that if I choose to drive after dilation, I do so at my own risk, and Bessemer Family Eye Care, LLC will in no way be held responsible.**

I authorize the release of any medical information necessary to process a claim on any insurance that I am a member of. I authorize the release of all medical records on the patient listed above to the referring and family physicians. I hereby assign to and authorize the payment directly to Bessemer Family Eye Care, LLC for all benefits payable under such an insurance policy. I realize that the insurance benefits may not pay the entire bill, and **I agree to pay the difference or the entire bill if necessary. I will be responsible for paying all co-pays and/or deductibles at the time of the visit.** In the event of default in the payment of my charges, I agree to pay all costs of collections, including a reasonable attorney's fee, should the account be referred to an attorney for collection.

I understand that some services are not always covered as dictated by my insurance company based on the medical necessity. I understand that if any treatment is rejected by my insurance plan as a non-covered procedure, **I will be billed for those services.** I acknowledge as a member of these plans that this office will submit my insurance claim, and **I will be responsible for paying all copays and/or deductibles at the time of the visit.**

I authorize my insurance company to remit payment of medical benefits directly to this office for services provided.

Signature of Responsible Party: _____ Date: _____

Relationship to Patient: _____