PATIENT INFORMATION

Today's Date: ____________________ Date of last eye exam: __________________________

Patient Name: ______________________________________ Date of Birth: _____________________

Address (City/State/Zip): ____

Phone Number: _______________________ Email: ____

Emergency Contact: _______________________________ **Phone Number:** ____________________

Whom may we thank for referring you? ____

MEDICAL HISTORY

If you answer YES to any of the following questions, please use the space provided to explain.

Do you have any allergies to medication? [ ] N [ ] Y ______________________________________

List any medications you take (including oral contraceptives, aspirin, over-the-counter medications and home remedies):

____

____

List all major injuries, surgeries, and/or hospitalizations you've had:

____

Are you pregnant or nursing? [ ] N [ ] Y

Do you wear glasses? [ ] N [ ] Y If so, how old is your present pair of lenses? _________________

Do you wear contact lenses? [ ] N [ ] Y If so, how old is your present pair of lenses? ____________

Type of contact lenses: [ ] Rigid [ ] Soft [ ] Extended Wear [ ] Other: __________

Are they comfortable? [ ] N [ ] Y

FAMILY HISTORY

Please note any family history (parents, grandparents, siblings, children) for the following conditions:

[ ] Blindness / Cataracts / Crossed Eyes _______________________________________

[ ] Glaucoma / Macular Degeneration ____

[ ] Arthritis ____

[ ] Retinal Detachment / Disease ____

[ ] Cancer ____

[ ] Diabetes ____

[ ] Heart Disease / High Blood Pressure ____

[ ] Kidney Disease ____

[ ] Lupus ____

[ ] Thyroid Disease ____

[ ] Other: ____

SOCIAL HISTORY

This information is kept strictly confidential. However, you may discuss this portion directly with your doctor, if you'd prefer.

Do you drive? [ ] N [ ] Y If so, do you ever experience difficulty when driving? [ ] N [ ] Y

Do you use tobacco / alcohol products? [ ] N [ ] Y Amount / type: ___________________________

Do you use illegal drugs? [ ] N [ ] Y Amount / type: ______________________________________

Have you ever been infected with: [ ] Gonorrhea [ ] Hepatitis [ ] HIV [ ] Syphilis

REVIEW OF BODY SYSTEMS

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

Condition	Yes	No	Explain / Medications
Constitutional (fever, weight loss / gain)			
Integumentary (skin)			
Neurological (headaches, migraines, seizures)			
Eyes (loss of vision, blurred vision, double vision, dryness, itching, excess tearing, sties, flashes or floaters, infections, light sensitivity)			
Ears / Nose / Throat (allergies, congestion, runny nose, chronic cough, dry throat, dry mouth)			
Respiratory (asthma, chronic bronchitis, emphysema)			
Vascular / Cardiovascular (diabetes, heart pain, high blood pressure, vascular disease)			
Gastrointestinal (constipation)			
Genitourinary (genitals, kidneys, bladder)			
Bones /Joints / Muscles (Rheumatoid Arthritis, muscle or joint pain)			
Lymphatic / Hemotologic (anemia or bleeding problems)			
Endocrine			
Allergic / Immunologic			
Psyciatric			
Other			

Patient/Guardian signature: ___________________________________ Date: _____________________

Doctor signature: ____ Date: _____________________

OFFICE POLICIES / CONSENTS

AUTHORIZATION AND RELEASE FOR BILLING

I hereby authorize Dr. Chad Jackson, O.D. to furnish my vision and/or medical records to my insurance company for determination of payment. I understand that my insurance carrier may deny a claim or pay less than the actual bill for services. I acknowledge that it is my responsibility to know what my insurance covers prior to services being rendered. I also acknowledge that I am responsible for paying any deductibles, co-payments or co-insurance due for myself and/or my dependents. I understand that any unpaid balance may be subjected to a finance charge and/or collection fees, should my account become delinquent.

Patient/Guardian: ____

Date: ________________________________

NOTICE OF HIPAA PRIVACY PRACTICES

I authorize that I have been presented with Chad J. Jackson's Notice of Privacy Practices and have been offered a copy to keep with my records. I understand the staff of Bella Vista Family Eye Care will keep all of my vision/medical records confidential and that my information will not be shared with any other entity, unless I give prior authorization.

Patient/Guardian: ____

Date: ________________________________

HIPAA APPROVED ENTITIES

It is the policy of Bella Vista Family Eye Care to communicate with our patients via phone, email or regular mail regarding appointments, exam results, payments, orders, etc. In order to ensure that you receive the information in a timely fashion we may provide such information to people of your choosing. Please list the approved entities below. You may change this authorization at anytime.

Name: ____

Relationship: ____

Name: ____

Relationship: ____

Patient/Guardian: ____

Date: ________________________________