

Last Name _____ First Name _____ MI _____ Date _____
Home Address _____ City _____ State _____ Zip _____
Birth date _____ Sex _____ Social Security Number _____ Marital Status _____
Email _____ Employer/School _____ Occupation _____
Home _____ Cell _____ Work _____ Preference? _____
Name of Parent, Legal Guardian or Spouse _____
Name of other family members whom we have provided care _____
Vision and Medical Insurance Company _____ ID# _____
Subscriber Name _____ Subscriber birth date _____ Relationship to Patient _____

Race (Optional): Please circle

American Indian or Alaskan Native Asian African American or Black Native Hawaiian or other Pacific Islander
Caucasian or White **Ethnicity (Optional):** Hispanic or Latino Not Hispanic or Latino

Medical History / Review of Systems:

Please list any medications you are now taking (including eye drops, birth control pills, vitamins or over the counter medications): _____

Are you allergic to any medications: YES NO Please list: _____

Primary Care Physician: _____ Pediatrician: _____

Preferred Pharmacy: _____ Location: _____ Phone: _____

Do you have or ever had any of the following problems:

- | | |
|---|---|
| <input type="radio"/> Asthma | <input type="radio"/> Gastrointestinal Problems |
| <input type="radio"/> Diabetes | <input type="radio"/> Heart Problems |
| <input type="radio"/> High Blood Pressure | <input type="radio"/> Musculoskeletal Problems |
| <input type="radio"/> High Cholesterol | <input type="radio"/> Neurological |
| <input type="radio"/> Thyroid Problems | <input type="radio"/> Depression/Anxiety |
| <input type="radio"/> Arthritis | <input type="radio"/> Respiratory Problems |
| <input type="radio"/> Chronic Fever | <input type="radio"/> Seasonal Allergies |
| <input type="radio"/> Ear/Nose/Throat | <input type="radio"/> Skin Problems |
| <input type="radio"/> Endocrine Problems | <input type="radio"/> Urinary Problems |
| <input type="radio"/> Pregnant/Nursing | <input type="radio"/> Hepatitis |
| <input type="radio"/> AIDS | |

Other conditions or illness: _____

List any previous major injuries/surgeries/hospitalizations: _____

Eye History: Do you have or have you ever had any of the following problems:

- | | | |
|--------------------------------------|--|--|
| <input type="radio"/> Blurred Vision | <input type="radio"/> Eye Surgery | <input type="radio"/> Loss of Vision |
| <input type="radio"/> Cataracts | <input type="radio"/> Flashers | <input type="radio"/> Macular Degeneration |
| <input type="radio"/> Double Vision | <input type="radio"/> Floaters | <input type="radio"/> Migraine/Headache |
| <input type="radio"/> Dry Eye | <input type="radio"/> Glaucoma | <input type="radio"/> Retinal Detachment |
| <input type="radio"/> Eye Injury | <input type="radio"/> Lazy/Crossed Eye | |

Are you interested in correcting your vision with LASIK Surgery? _____

Family History: (Mother, Father, Siblings, Grandparents)

- | | | |
|--|--|---|
| <input type="radio"/> Blindness | <input type="radio"/> Macular Degeneration | <input type="radio"/> Other Eye Disease or Condition: _____ |
| <input type="radio"/> Cataracts | <input type="radio"/> Retinal Detachment | _____ |
| <input type="radio"/> Glaucoma | <input type="radio"/> Diabetes | _____ |
| <input type="radio"/> Lazy/Crossed Eye | <input type="radio"/> High Blood Pressure | _____ |

Do you drive? Y/N If yes, do you have visual difficulty when driving? Y/N

If yes, please describe _____

Smoking and Alcohol History

- | | |
|--|-------------------------------------|
| <input type="radio"/> Current every day smoker | Do you drink Alcohol? Y/N _____ |
| <input type="radio"/> Current some day smoker | Do you use illegal drugs? Y/N _____ |
| <input type="radio"/> Former smoker | |
| <input type="radio"/> Never smoker | |

If patient is 18 or under, please complete:

Any prenatal, perinatal or postnatal problems? Y/N _____

Any developmental problems? Y/N _____

Do you have any concerns with your child's school performance? _____

Last eye care provider: _____ Date of last exam: _____

Are you currently having eye or vision problems? Y/N If yes, please explain: _____

Do you wear glasses? Y/N How old are they? _____

Have you ever worn contact lenses? Y/N If yes, when were they prescribed? _____

Do you wear contact lenses now? Y/N If not, why did you quit? _____

Are you interested in wearing contact lenses? Y/N If yes, please read the following regarding contact lenses:

Bloomberg Eyecare prescribes quality contact lenses to improve your vision and lifestyle. Contact lenses are FDA regulated medical devices that can cause discomfort, infections and even permanent vision loss if not cared for properly. New and existing contact lens wearers require additional time and testing during and eye exam to minimize the risk of serious eye problems. This additional testing is only done for contact wearers, not for patients who do not wear contact lenses. For this reason, there are additional contact lens evaluation and service fees for new and existing contact lens wearers. Your contact lens evaluation and services fee includes:

1. Specific curvature measurements of the corneas.
2. Evaluation of current and new lenses to ensure optimal fit, vision and comfort.
3. Medical assessment of the cornea, tear film and conjunctiva as they relate to contact lens wear.
4. Instructions regarding safe contact lens wear, care and proper cleaning and solutions.
5. Contact lens follow up care for 90 days.

If you have any questions, please do not hesitate to speak with your doctor.

- Payment for all services and products is the responsibility of the patient. PAYMENT IN FULL IS REQUIRED AT TIME OF SERVICE.**
- I agree to pay all co-pays, deductibles, co-insurances and non-covered services as determined by my insurance company.**
- I understand that there is a returned check fee applied to every returned check.**
- I authorize the release of medical information regarding my illness and treatment by Bloomberg Eyecare to my insurance company.**
- I also authorize the release of my personal medical information to any doctor to whom I may be referred.**
- I understand that verification of eligibility is not a guarantee of payment as stated by my insurance company.**
- I authorize payment of my insurance benefits to Bloomberg Eyecare.**
- We will file all insurance forms if Bloomberg Eyecare is a participating provider for your plan.**
- We will supply to you an itemized statement which you may submit to your insurance carrier.**

SIGNATURE OF PATIENT OR LEGAL GUARDIAN

TODAY'S DATE

HIPPA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose health information about you. The notice contains a Patient's Rights section describing your rights under the law. You have the right to review our notice before signing this consent. The terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment or other health care options. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made based on your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

The patient understands:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The practice has a Notice of Privacy Practices and the patient has the opportunity to review this notice.
- The practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the use of their information but the practice does not have to agree to those restrictions.
- The patient may revoke this consent in writing at any time and all future disclosures will then cease.
- This practice may condition receipt of treatment upon the execution of this consent.

Patient or Representative Signature: _____ Date: _____

Printed Name: _____