BEEVE VISION CARE CENTER

Jerold E. Beeve, MD, FACS & Scott W. Beeve, MD, FACS
1809 Verdugo Blvd., Suite 150
Glendale, CA 91208
Phone: 818.790.8001 • Fax: 818.790.7757

ACCT #: _____

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Ph: (___) _____ Cell Ph: (___) _____ Work Ph: (___) _____

Social Security #: _____ Date of Birth: _____ ❑ Male ❑ Female

Marital Status: _____ Occupation: _____

Name of Employer: _____

Employers Address: _____

E-Mail Address: _____ Referred By: _____

In Case of Emergency

Contact Person: _____ Phone #: _____ Relationship: _____

MEDICAL INSURANCE INFORMATION

Primary Insurance: _____ Subscriber's ID #: _____

Subscriber's Name: _____ Relationship to Subscriber: _____

Secondary Insurance: _____ Subscriber's ID #: _____

Subscriber's Name: _____ Relationship to Subscriber: _____

VISION INSURANCE

❑ Vision Service Plan ❑ Medical Eye Services ❑ Superior Vision Plan ❑ Davis ❑ EyeMed

❑ Other: _____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I, the undersigned, being the patient/legal guardian/person having legal custody/or person otherwise having legal authorization to consent freely give my consent to Dr. Jerold E. Beeve, Dr. Scott W. Beeve and Associates, to examine and treat the patient registered above. I authorize my records to be released that may be requested for the purpose of paying for services rendered, and authorize the payment from any such medical benefits be made to our practice. I understand that dilating drops may be used in my examination and may blur my vision, making it unsafe to drive. I will not attempt to drive until I feel certain the effect of the medication has worn off. The effect may last an hour or longer.

_____ _____

Signature of Patient/Legal Guardian Date

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EYE HISTORY

NAME: _____

Thank you for choosing our office for your eye care. To better serve you, please answer the following:

1. Do you wear glasses? ❑ Yes ❑ No Contact Lenses? ❑ Yes ❑ No Problems reading? ❑ Yes ❑ No

2. Are you currently experiencing any eye symptoms? Check all that apply.

❑ Eye pain	❑ Blurred vision	❑ Eyelid crusting	❑ Flashes of light	❑ Halos
❑ Discharge	❑ Light sensitivity	❑ Double vision	❑ Decreased vision	❑ Floaters

3. Please indicate if you've had any problems with the following:

		Explanation of Problem
GENERAL/CONSTITUTIONAL (fever, weight loss, etc.)	❑ Yes ❑ No	
EARS, NOSE, THROAT (sore throat or cold)	❑ Yes ❑ No	
CARDIOVASCULAR (heart, poor circulation, etc.)	❑ Yes ❑ No	
RESPITORY (shortness of breath, cough)	❑ Yes ❑ No	
GASTROINTESTINAL (stomach ulcers, intestinal diseases, etc.)	❑ Yes ❑ No	
GENITAL, KIDNEY, BLADDER (painful urination)	❑ Yes ❑ No	
MUSCLE, BONES, JOINTS (stiffness aches, etc.)	❑ Yes ❑ No	
SKIN (acne, warts, skin cancer, etc.)	❑ Yes ❑ No	
NEUROLOGICAL (numbness, weakness, etc.)	❑ Yes ❑ No	
PSYCHIATRIC (anxiety, depression, insomnia, etc.)	❑ Yes ❑ No	
ENDOCRINE (hot flashes, etc.)	❑ Yes ❑ No	
BLOOD/LYMPH (light headedness, etc.)	❑ Yes ❑ No	
ALLERGIC/IMMUNOLOGIC (hay fever, rashes, etc.)	❑ Yes ❑ No	

4. Have you ever had an eye injury? Please describe: _____

_____

PLEASE CONTINUE ON OTHER SIDE

5. Have you ever had eye surgery? Please list type, which eye and approximate dates:

_____ ❑ R ❑ L _____

_____ ❑ R ❑ L _____

6. Are you being treated for any medical conditions? Check all that apply.

❑ Diabetes ❑ Heart disease ❑ High blood pressure ❑ Stroke ❑ Arthritis

7. Are you currently using any eye medications? Please list names and how often used:

_____ _____ _____

_____ _____ _____

8. What medications (other than the above) are you taking? Please list the names and how often used:

_____ _____ _____

_____ _____ _____

9. Are you allergic to any medications? Please list:

_____

_____

10. Do you have a family history of eye problems? Please check and list family relationship:

❑ Glaucoma _____ ❑ Macular Degeneration _____

❑ Cataract _____ ❑ Retinal Disease _____

11. Please check any of the following that you would like more information about:

❑ LASIK Correction ❑ Contact lenses ❑ Cataract Surgery

❑ Diabetic Eye Disease ❑ Glaucoma ❑ Other: _____

Scott W. Beeve, MD, FACS
Board Certified Ophthalmologist
LASIK & Cataract Surgeon
Comprehensive Eye Care

Jerold E. Beeve, MD, FACS
Eye Physician & Surgeon
Diplomate, American Board of Ophthalmology

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SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS AND FINANCIAL AGREEMENT

_____
NAME (PRINT)

1. **MEDICARE**: I request that payment of authorized Medicare benefits be made on my behalf to **Jerold E. Beeve / Scott W. Beeve M.D., Inc.**, for services furnished to me by **Jerold E. Beeve / Scott W. Beeve M.D., Inc.** I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on the other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. **Jerold E. Beeve / Scott W. Beeve M.D., Inc.** accepts the charge determination of the Medicare carrier as the full charge, **and I am responsible only for the deductible, coinsurance and non-covered services**. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

2. **MEDIGAP**: I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to **Jerold E. Beeve / Scott W. Beeve M.D., Inc.** if possible or otherwise to me.

3. **RELEASE OF INFORMATION**: **Jerold E. Beeve / Scott W. Beeve M.D., Inc.** may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to **Jerold E. Beeve / Scott W. Beeve M.D., Inc.** for reimbursement for services rendered, and (2) any healthcare provider for continued patient care. **Jerold E. Beeve / Scott W. Beeve M.D., Inc.** may also disclose on an anonymous basis, any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal Law, status or regulation.

4. **OTHER INSURANCE**: I understand that **Jerold E. Beeve / Scott W. Beeve M.D., Inc.** maintains a list of healthcare service plans with which it contracts. Lists of such plans are available from the business office and that **Jerold E. Beeve / Scott W. Beeve M.D., Inc.** has no contract, expressed or implied, with any insurance that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by **Jerold E. Beeve / Scott W. Beeve M.D., Inc.** if I belong to a plan that does not appear on the above-mentioned list.

5. **NON-COVERED SERVICES**: I understand that **Jerold E. Beeve / Scott W. Beeve M.D., Inc.**, contracts with healthcare service plans (i.e., HMO's, PPO's, etc.), state items and services, which are "covered" by the health service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the healthcare service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a healthcare service plan or in the benefit summary the healthcare plan furnishes to the patient and treatment or test not authorized by the healthcare service plan. The undersigned agrees to cooperate with **Jerold E. Beeve / Scott W. Beeve M.D., Inc.** to obtain necessary healthcare service plan authorizations.

6. **FINANCIAL AGREEMENT**: I agree that in return for the services provided to the patient by **Jerold E. Beeve / Scott W. Beeve M.D., Inc.**, I will pay my account at the time services are rendered or will make financial arrangements satisfactory to **Jerold E. Beeve / Scott W. Beeve M.D., Inc.** as payment. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, are hereby assigned to **Jerold E. Beeve / Scott W. Beeve M.D., Inc.** If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to **Jerold E. Beeve / Scott W. Beeve M.D., Inc.** **However, it is understood that the undersigned and/or the patient is primarily responsible for the payment of my bill.**

_____ _____
SIGNATURE OF PATIENT/GUARDIAN OR RESPONSIBLE PARTY DATE