BEGGS FAMILY VISION

Philip J. Beggs, O.D. **Independent Doctor of Optometry**

Wellness Vision Exam (Please do not fill out this form if you have any of the following: diabetes, cataracts, glaucoma, flashes of light, retinal disease, red eye, or eye pain. Ask the assistant for the medical form.)

Name_____ Date of Birth_____/_____/_____ Date____/____/_____

Address_____ City_____ Zip _____

Phone _____ Occupation_____ Hobbies_____

Method of Payment: ___Cash ___Insurance ____Check ($35 charge on returned checks) ____Credit

Insurance patients only: (Prior authorization required)

Insurance company name _____ Insured ID # _____

Assignment of Benefits: I hereby instruct and direct the insurance company named above to pay the provider, Philip J. Beggs, O.D., for the professional and or medical expense benefits allowable toward the total charge(s) for the professional charge(s) rendered. This is a direct assignment of my benefits under this policy. I have agreed to pay, in a current manner, any balance of said professional charge(s) over and above this insurance payment.

Patient (Parent) Signature _____

Date of last complete eye exam _____ Reason for visit:___Wellness vision exam_____

Type of glasses you wear? ___None ___Single vision ___Bifocal ___Trifocal ___No-line progressive

Contact exam today? Y or N If yes, what type do you wear? __Soft __Hard __Color __Bifocal/Mono

Contact lens patients only: Within two month of date of exam, follow-ups related to the fitting of the contacts are at no charge. Visits related to eye infections are excluded. All follow-ups after the two month period will be charged $30 per visit**. I agree to the follow-up policy _____**
Initial

Medical History (Mark "**S**" for Self and "**F**" for Family)

- ___Glaucoma	- Flashes of light	- ___Floaters	- ___High blood pressure
- Macular degeneration	- Cataracts	- ___Diabetes	- ___Loss of vision
- Eye injury	- Lazy eye	- ___Retinal detachment	- ___Other _____

List medications _____ Drug allergies_____ Are you currently pregnant or nursing? - If yes, notify the doctor.

Pupil Dilation

Dilation is recommended for evaluating the health of the eye. Dilation will cause sensitivity to light and near blur for 3-6 hours. **There is no additional charge for this service.** Please ***initial*** next to Yes or No. If you do not initial, the optometrist will decide for you.

_____Yes, dilate my eyes. **_____No, I refuse dilation.**
Initial Initial

HIPAA Privacy Notice

I have reviewed the HIPPA policy and understand that my medical records will not be released without my written consent.

Patient (Parent) Signature _____

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