Date:_____________________ Social Security # ____________________

Name:____ Date of Birth:_____________ Age: _____

Address:________________________________ City:________________ State:_________ Zip: _______

Home#:_______________________ Cell#:_________________________Work#:___________________

E-mail:___________________________________ Status: Married Single Divorced Widowed

Work Place/School:____________________________ Occupation/Grade: ________________________

Emergency Contact (Name/Phone): ____

Primary Language:______________ Race:____________ Ethnicity:___________ Gender: ____________

How did you hear about our office? ____

Primary Care Doctor:______________________ Last exam:_____________ Pharmacy:______________

Last Eye Exam:____________________________ Last Eye Doctor: _______________________________

Do you wear glasses?__________ How often do you wear sunglasses? ___________________________

How old are your glasses?____________ Do you wear Contacts? (Brand/Power) ___________________

How many hours/day do you use the computer? _____ Do you get strain from computer work? ______

Social History: Tobacco: Type/Frequency? _______________ Alcohol: Frequency? ______________

Ocular History – please check all that apply

- ☐ Cataracts
- ☐ Macular Degeneration
- ☐ Glaucoma
- ☐ Diabetes
- ☐ Diabetic Retinopathy
- ☐ Dry Eye
- ☐ Eye infection, Inflammation, Allergy
- ☐ Floaters/Flashes of light
- ☐ Iritis or Uveitis
- ☐ Retinal Defects or Degenerations
- ☐ Other: __________________________
- ☐ None

Vision and Eye Concerns

- ☐ Redness
- ☐ Burning
- ☐ Itching
- ☐ Tearing
- ☐ Discharge
- ☐ Blurred Vision
- ☐ Eye Strain
- ☐ Eye Pain
- ☐ Severe Light Sensitivity
- ☐ Headache
- ☐ Poor Night Vision
- ☐ Night Glare
- ☐ Double Vision
- ☐ Total Loss of Vision
- ☐ Other: __________________________
- ☐ None

Immediate Family History – Please list Father, Mother, Brother, Sister or Children

- ☐ Blindness ________________________
- ☐ Lazy Eye _________________________
- ☐ Glaucoma _______________________
- ☐ Macular Degeneration ______________
- ☐ Cancer __________________________
- ☐ Diabetes ________________________
- ☐ High Blood Pressure _______________
- ☐ Heart Disease ____________________
- ☐ Thyroid _________________________
- ☐ Other___________________________

BISSELL
Eye Care

Medical History

Please list all prescription and over the counter medications that you currently are taking:

____

____

____

Allergies to medications? ____

Please list any major injuries/surgeries:

Constitution

- ☐ Weight gain/loss
- ☐ Fatigue
- ☐ Cancer
- ☐ Other:_____________

Ears, Nose, Throat, Mouth

- ☐ Seasonal Allergies
- ☐ Dry Mouth
- ☐ Hearing Loss
- ☐ Other:_____________

Neurologic

- ☐ Migraine
- ☐ Stroke
- ☐ Autism spectrum
- ☐ Seizures
- ☐ Other:_____________

Psychiatric

- ☐ Depression
- ☐ Anxiety
- ☐ Other:_____________

Cardiovascular

- ☐ High blood pressure
- ☐ Heart Disease
- ☐ Other:_____________

Respiratory

- ☐ Asthma
- ☐ COPD
- ☐ Sleep apnea
- ☐ Other:_____________

Gastrointestinal

- ☐ Crohn's disease
- ☐ Celiac disease
- ☐ Other:_____________

Genitourinary

- ☐ Kidney disease
- ☐ Pregnant/Nursing
- ☐ Other:_____________

Muscular/Skeletal

- ☐ Fibromyalgia
- ☐ Osteoarthritis
- ☐ Other:_____________

Skin

- ☐ Rosacea
- ☐ Other:_____________

Endocrine

- ☐ Diabetes
- ☐ Thyroid
- ☐ Other:_____________

Hematologic/Lymphatic

- ☐ High cholesterol
- ☐ Anemia
- ☐ Other:_____________

Allergy/Immunologic

- ☐ Lupus
- ☐ Rheumatoid arthritis
- ☐ Sjogrens syndrome
- ☐ Other:_____________

To be seen in a timely manner, please find out which vision insurance company you carry. Come to the office early to insure we have all necessary information, <u>along with your insurance cards.</u>

Vision Insurance: ___________________________ ID# ______________________________
(VSP, VBA, Davis, EyeMed, etc.) (Some vision plans have no card)

Policy Holder's Name: __________________________ DOB: ______________________________

Policy Holder's Phone #: _________________________ SS#: ______________________________

Policy Holder's Address:______________________________ ______________________________
(With some insurance, we need the SS# to get the authorization)

Medical Insurance: ___________________________ID# ______________________________
(Highmark, UPMC, CIGNA, United HealthCare, Medicare, etc.)

Policy Holder's Name: __________________________ DOB: ______________________________

Policy Holder's Phone #: _________________________ SS#: ______________________________

Policy Holder's Address:____

Authorization and Release

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my dependents to any third payer and/or other health care practitioner involved in my care.

I authorize and request my insurance company to pay Bissell Eye Care, LLC directly for services rendered.

I understand my insurance plan may pay less than the actual bill for services; therefore, I agree to be responsible for any payment beyond what my insurance company determines to be the maximum benefit provided. If for whatever reason my insurance company denies payment to Bissell Eye Care, LLC, I understand that I am responsible for the balance.

____ __________________

Patient/Guardian Signature Date

OCULAR HEALTH SCREENING TOOL

A new, highly sophisticated computerized instrument now allows us to take high quality digital images of the retina and other structures inside your eye. This procedure assists the doctor in early detection of many disorders, including glaucoma, diabetic retinopathy, macular degeneration, retinal detachments and many other vision threatening conditions. The images are stored in our computer and can be compared with images in the future, allowing us to observe even the smallest amount of change. The images can also be printed and shared with your family physician or specialist if necessary.

We strongly recommend that *all* patients have this procedure performed and it is especially important for people who have:

1. Headaches
2. See spots or flashes
3. Family history of diabetes
4. Family history of glaucoma
5. High blood pressure
6. High cholesterol
7. Reached the age of 40
8. Sudden vision change
9. Your vision is not correctable to 20/20
10. Never had the procedure previously
11. Have had retinal disorders such as a detachment, tear or floaters
12. Would like a “baseline” image for future comparison

Screening retinal photography is a **NECESSARY** part of your eye exam if you fall into **ANY** of the above categories. There is an additional charge of $35.00 for this screening procedure and it is **NOT COVERED** by insurance if the screening does not detect any unusual condition. If pathology or a risky condition is documented with these photos, or more are needed, this "photographic study" can be billed to your health insurance as part of your treatment plan, **deductibles may apply**.

Please check the appropriate line below and sign at the bottom.

______ **I ACCEPT** having the procedure done

______ **I DECLINE** having the procedure done

____ __________________

Patient/Guardian Signature Date

HIPAA AUTHORIZATION FORM

I, ______________________, give permission to Bissell Eye Care to discuss or release health information identifying me to my insurance company/companies, to any referring or consulting physicians or entities, and to the following.

List of authorized people and entities (suggestions: parents, spouse, caretakers):

____

____

____

Description of information to be produced: medical and financial (amount billed, payments, etc).

This authorization is being made voluntary and at my request.

I understand that:

If the above listed person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations (e.g. If you release your information to your spouse we have no control of what your spouse may do with the information).

I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.

I may inspect or copy the protected health information to be used or disclosed under this authorization. For protected health information created as part of a clinical trial, my right to access is suspended until the clinical trial is completed.

Bissell Eye Care has a comprehensive Notice of Privacy Practices available that describes these uses and disclosures in detail. I am free to refer to this Notice at any time.

Finally, I may revoke this authorization in writing at any time by notifying the office. My notice will not apply to actions taken prior to the date they receive my written request to revoke authorization.

I have read and understand the above information.

______________________________________	______________________
Signature of Patient or Personal Representative	Date
______________________________________	______________________
Printed Name	Relationship/Authority

If you would like this authorization to expire note here (date/event):______________________