BELLINGHAM eye PHYSICIANS

PATIENT INFORMATION FORM

A. Patient Demographics

Name:_____ Social Security #:_____

DOB:_____ **Marital Status : S [ ] M [ ] Other [ ]** Sex: M [ ] F [ ]

Mailing Address:_____

Home Phone:_____ Cell Phone:_____

Employer:_____ Work Phone:_____

May we contact you via email? Y___ N___ Email Address:_____

B. Responsible Party (if policyholder is different from patient):

Parent/Spouse:_____ SSN#:_____ DOB:_____

Parent/Spouse Mailing Address:_____

Parent/Spouse Employer:_____ Work Phone:_____

C. In Case of EMERGENCY:

Person to Contact:_____ Phone:_____

Relationship to Patient:_____

D. Primary Care Physician:_____

E. Financial Responsibility:

I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agree to pay for all costs and expenses, including reasonableattorney fees, 1 hereby assign benefits to be paid directly to the doctor and authorize him to furnish information regarding my illness to my insurance company.

F. I acknowledge I have been offered a copy of this office's Notice of Privacy Practices (available upon request):

_____

(Patient or Authorized Representative Signature) **(Date)**

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PATIENT RESPONSIBILITY FORM

1. INDIVIDUALS FINANCIAL RESPONSIBILITY

- I understand that I am financially responsible for my health insurance deductible, coinsurance, or non-covered service.
- Co-payments are due at time of service.
- If my plan requires a referral, I must obtain It prior to my visit.
- In the event that my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided.
- If I am uninsured, I agree to pay for the medical services rendered to me at time of service.
- I understand that Bellingham Eye Physicians is **not contracted** with most routine vision insurances and are unable to submit to these companies. I am aware my exam may not be covered by my medical insurance in the event I have routine coverage through these separate insurances.

2. INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

- I hereby authorize and direct payment of my medical benefits to BELLINGHAM EYE PHYSICIANS on my behalf for any services furnished to me by the providers.

3. AUTHORIZATION TO RELEASE RECORDS

- I hereby authorize BELLINGHAM EYE PHYSICIANS to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization, or referral to other medical provider.

4. REFRACTION ALLOWANCE

- **I understand that my insurance may not include a refraction as part of my benefits. I understand that Bellingham Eye Physicians is unable to determine this prior to receiving this service. I understand that if my insurance company does not provide payment, I am responsible for the $50.00 refraction charge. I understand that this service is <u>NOT</u> required and if I decline it, I will not receive a prescription for glasses.**

_____

(Print Name) (Date of Birth

_____

(Patient or Authorized Representative Signature) (Date)

PATIENT AUTHORIZATION FORM

Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, significant other, parents or children to call and request the result of tests, procedures and financial information. Under the requirements for H.I.P.A.A. we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, any diagnostic test results and/or financial information released to any family members you must sign this form. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize Bellingham Eye Physicians to release my records and any information requested to the following individuals.

1. _____ Relation to Patient:_____

2. _____ Relation to Patient:_____

Authorization Regarding Messages

(Please check all that apply)

____ I authorize you to leave a detailed message on my home or cell number regarding appointments

____ I authorize you to leave a detailed message on my home or cell number regarding medical treatment, care, test results or financial information

____ I authorize you to leave a message with anyone who answers the phone

____ Messages may only be left with _____

_____ Date of Birth

_____ Patient Name (PLEASE PRINT)

_____ Date

_____ Patient Signature

Health History

Patient Name:_____ DOB:_____ Gender: M [__] F [__]

Were you referred; by whom?_____ Primary Care Doctor:_____

What is your main concern for today's visit?_____

_____ Would you like a glasses prescription today? Y [__] N [__]

Do you have any drug allergies? Y [__] N [__] If YES, please list: _____

_____

Please list any medications (or supply a meds list):_____

_____

_____ Preferred Pharmacy: _____

Marital Status : S [__] M [__] W [__] D [__] Are you nursing or pregnant? Y [__] N [__]

Race:

- Native American_____[__]
- White_____[__]
- Asian_____[__]
- Black/African American_____[__]
- Native Hawaiian/Other Pacific Islander_____[__]
- Hispanic_____[__]
- Declined_____[__]

Tobacco Use:

- Never_____[__}
- Everyday_____[__]
- Socially_____[__]
- Former_____[__]

Are you currently experiencing any of the following visual symptoms?

- Blurred Vision_____[ ]
- Decreased Distance Vision___[ ]
- Decreased Near Vision_____[ ]
- Dry Eye _____[ ]
- Double Vision_____[ ]
- Eye Pain_____[ ]
- Flashing Lights_____[ ]
- Floaters_____[ ]
- Glare_____[ ]
- Halos_____[ ]
- Headache_____[ ]
- Itchy Eyes_____[ ]
- Red Eye(s)_____[ ]
- Tearing (watering)_____[ ]
- Foreign Body Sensation_____[ ]

NEW PATIENTS PLEASE CONTINUE
(Also needed every three years)

EXISTING PATIENTS TURN OVER TO SIGN (YEARLY)

Eye History

	[Y]	[N]
Do you currently wear glasses?_____	[__]	[__]
Do you currently wear contacts?_____	[__]	[__]
Have you ever had eye surgery? ____	[__]	[__]

If YES, what procedure and which eye?_____

_____

	[Y]	[N]
Have you ever injured your eye?_____	[__]	[__]

If YES, please describe:_____

_____

(CONTINUED ON THE BACK)

Have you or any family member been diagnosed with any of the following eye conditions?
(Please indicate if personal or family history of illness)

	Self: [Y]	[N]	[Family]	Family Member (Parent, Grandparent etc)
Amblyopia/Lazy Eye	[ ]	[ ]	[ ]	
Cataract	[ ]	[ ]	[ ]	
Diabetic Retinopathy	[ ]	[ ]	[ ]	
Dry Eye	[ ]	[ ]	[ ]	
Glaucoma	[ ]	[ ]	[ ]	
Keratoconus	[ ]	[ ]	[ ]	
Macular Degeneration	[ ]	[ ]	[ ]	
Misalignment/Strabismus	[ ]	[ ]	[ ]	
Retinal Tear/Detachment	[ ]	[ ]	[ ]	

	[Y]	[N]	
Prescription or non-prescription medication for eyes?	[ ]	[ ]	If YES please list:

Medical History

Do you or a family member have any of the following medical diagnoses?
(Please indicate if personal or family history of illness)

	Self:[Y]	[N]	[Family]	Family Member (Parent, Grandparent etc)
Allergies	[ ]	[ ]	[ ]	
Arthritis	[ ]	[ ]	[ ]	
Asthma	[ ]	[ ]	[ ]	
Back problems	[ ]	[ ]	[ ]	
Cancer	[ ]	[ ]	[ ]	
If YES what type:				
COPD	[ ]	[ ]	[ ]	
Depression	[ ]	[ ]	[ ]	
Diabetes	[ ]	[ ]	[ ]	
Gout	[ ]	[ ]	[ ]	
Heart Disease	[ ]	[ ]	[ ]	
Hypertension	[ ]	[ ]	[ ]	
High Cholesterol	[ ]	[ ]	[ ]	
Kidney Disease	[ ]	[ ]	[ ]	
Migraine/Headache	[ ]	[ ]	[ ]	
Neurological Disease	[ ]	[ ]	[ ]	
Osteoporosis	[ ]	[ ]	[ ]	
Reflux	[ ]	[ ]	[ ]	
Seizures	[ ]	[ ]	[ ]	
Sinusitis	[ ]	[ ]	[ ]	
Stroke	[ ]	[ ]	[ ]	
Thyroid Disorder	[ ]	[ ]	[ ]	
Other	[ ]			

If other, please describe:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that it is my responsibility to inform the doctor of any changes in my medical status.

Patient (or guardian) Signature

Date