Health History

Patient Name:_____ DOB:_____ Sex at Birth: M [__] F [__]

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

Main concern for today's visit? _____

Would you like a glasses prescription? Y [__] N [__] If Needed [__]

(NOTE: THE TEST FOR A GLASSES PRESCRIPTION MAY NOT BE COVERED BY YOUR INSURANCE)

Would you like a contact lens prescription? Y [__] N [__] If Needed [__]

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 [ ]
- Other: _____

Eye History

[Y]

Do you currently wear glasses? [__] Readers only [__]

Do you currently wear contacts? [__] Previously worn Contacts? _____

Have you ever had eye surgery? [__] 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?

	Self:	Family	(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?

	Self:	Family	(Parent, Grandparent etc)
Allergies	[ ]	[ ]	
Alzheimers	[ ]	[ ]	
Arthritis	[ ]	[ ]	
Asthma	[ ]	[ ]	
Back problems	[ ]	[ ]	
Cancer	[ ]	[ ]	
			If **YES** what type:
COPD	[ ]	[ ]	
Depression	[ ]	[ ]	
Dementia	[ ]	[ ]	
Diabetes	[ ]	[ ]	
Blood Sugar: _____ A1C: _____			Year Diagnosed: _____
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

PATIENT RELEASE OF INFORMATION

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 ON BEHALF OF THE PATIENT TO REQUEST INFORMATION. THIS MAY INCLUDE TEST RESULTS, PROCEDURES AND APPOINTMENTS, AND FINANCIAL INFORMATION. UNDER THE REQUIREMENTS OF HIPAA, WE ARE NOT ALLOWED TO GIVE THIS INFORMATION TO ANYONE WITHOUT THE PATIENT'S CONSENT. IF YOU WISH TO HAVE YOUR MEDICAL INFORMATION RELEASED TO ANY FAMILY MEMBER, YOU MUST COMPLETE THIS FORM. YOU HAVE THE RIGHT REVOKE THIS CONSENT IN WRITING, EXCEPT WHERE WE HAVE ALREADY MADE DISCLOSURES IN RELIANCE OF YOUR PRIOR CONSENT.

I AUTHORIZE BELLINGHAM EYE PHYSICIANS TO RELEASE MY MEDICAL INFORMATION TO THE FOLLOWING INDIVIDUALS

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

AUTHORIZATION REGARDING VOICEMAIL AND TEXT MESSAGES

A. _____ I AUTHORIZE YOU TO LEAVE A DETAILED MESSAGE ON MY HOME OR CELL REGARDING MY MEDICAL INFORMATION

B. _____ I AUTHORIZE YOU TO SEND TEXT MESSAGES TO MY CELL REGARDING APPOINTMENT DATE AND TIME

C. _____ I AUTHORIZE YOU TO LEAVE A MESSAGE WITH ANYONE WHO ANSWERS MY PHONE

PATIENT DATE OF BIRTH: _____

PRINT PATIENT NAME: _____

PATIENT SIGNATURE: _____

DATE: _____

CONTINUED BACK

BELLINGHAM EYE PHYSICIANS

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.
- I understand that if I am unable to keep an appointment, I will notify Bellingham Eye Physicians within 24 hours. I understand that failure to do so will result in a no show fee of $50 on my account.

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 $60.00 refraction charge. I understand that this service is **NOT** required and if I decline it, I will not receive a prescription for glasses.

Patient Name _____ Date of Birth _____

Signature of Patient, Authorized Representative or Responsible Party _____ Date _____

CONTINUED ON BACK

BELLINGHAM EYE PHYSICIANS

REFRACTION LIABILITY NOTICE

THANK YOU FOR CHOOSING BELLINGHAM EYE PHYSICIANS FOR YOUR VISION HEALTHCARE. THIS FORM IS TO INFORM YOU ABOUT A POTENTIALLY NONCOVERED SERVICE.

REFRACTIONS ARE THE PORTION OF THE VISIT WHERE THE PHYSICIAN GENERATES A GLASSES PRESCRIPTION, **NOT** INCLUDING HARDWARE. **HARDWARE** MAY INCLUDE GLASSES LENSES, FRAMES, AND CONTACT LENSES.

YOU **MAY** HAVE THIS SERVICE DONE IF YOU HAVE VISION CHANGES INCLUDING BLURRED VISION, CATARACTS, DECREASED VISION ECT.

THIS CHARGE IS **SEPARATE** FROM THE REST OF THE HEALTH EXAM BEING DONE ON THE SAME DAY. REFRACTIONS ARE **OPTIONAL**, HOWEVER YOU WILL NOT RECEIVE AN UPDATED GLASSES PRESCRIPTION IF DECLINED.

BELLINGHAM EYE PHYSICIANS IS PRIMARILY A MEDICAL PRACTICE AND IS **NOT** IN NETWORK WITH ANY ROUTINE VISIONS PLANS SUCH AS VSP, EYE MED, OR METLIFE.

DUE TO INCREASED CHANGES IN HEALTHCARE COVERAGE, MOST MEDICAL INSURANCE COMPANIES **DO NOT** COVER THIS SERVICE. WE ARE UNABLE TO DETERMINE THIS AHEAD OF TIME FOR MOST PLANS AND **CANNOT GUARANTEE** COVERAGE.

WE WILL **ATTEMPT** TO BILL YOUR MEDICAL PLAN FOR THIS SERVICE. IF APPROVED, WE WILL REFUND THE DIFFERENCE BETWEEN ANY ADJUSTMENTS OR PAYMENTS MADE BY YOUR INSURANCE.

THE CHARGE FOR A REFRACTION IS $60, TO BE PAID AT THE **TIME OF SERVICE**. GLASSES PRESCRIPTIONS WILL **NOT** BE RELEASED WITHOUT PAYMENT. PAID REFRACTIONS ARE ACCESSIBLE AT **ANY TIME** DURING THEIR VALIDITY DATES, TYPICALLY 2 YEARS.

BY SIGNING BELOW YOU HAVE ACKNOWLEDGED THAT WE ARE **NOT IN NETWORK** WITH ANY **ROUTINE VISION PLAN** AND **YOU** WILL BE RESPONSIBLE FOR ANY SERVICES DEEMED NONCOVERED BY YOUR INSURANCE.

IF YOU HAVE QUESTIONS REGARDING THIS FORM OR SERVICE, PLEASE SPEAK WITH THE FRONT DESK OR THE BILLING DEPARTMENT. THANK YOU.

_____ _____

PATIENT NAME (PRINT) PATIENT DATE OF BIRTH

_____ _____

PATIENT SIGNATURE DATE