



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: _____

How did you hear about our office? _____

Primary Care Doctor: _____ Last exam: _____ Last Eye Exam: _____ 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 _____

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, along with your insurance cards.

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.

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): _____