



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:

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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



## 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 \$30.00 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 DO** want the procedure performed

\_\_\_\_\_ **I DO NOT** want the procedure performed

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Patient/Guardian Signature

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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):

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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): \_\_\_\_\_