BELL VISION OPTOMETRY

PATIENT REGISTRATION FORM

PATIENT INFO

Patient Full Name:			Date of Birth:	Age:	Sex:	Today's Date:
Street Address:			City:		State:	Zip:
Cell Phone:	Work/Other Phone:		Email Address:			
Occupation:		Employer Name:			☐ New Patient ☐ Existing Patient	

VISION INSURANCE INFORMATION

Insurance Provider:	Primary Member's Name:	Primary Member's Birthdate:
Primary Member's ID:	Relationship to Primary Member: ☐ Self ☐ Spouse ☐ Dependent	Primary Member's SSN:

REASON FOR TODAY'S VISIT

- ☐ Routine/Glasses Exam
- ☐ Contact Lens Exam
- ☐ LASIK Evaluation
- ☐ Retinal Evaluation/Imaging
- ☐ Dry Eye Evaluation
- ☐ Glaucoma Evaluation
- ☐ Specialty Contact Lens Fit (i.e., Scleral lenses, OrthoK)
- ☐ Other *(please specify)* ___________________________

PATIENT MEDICAL HISTORY

Date of your last comprehensive eye exam? __________ Do you wear glasses? ☐ N / ☐ Y Type (circle)? Distance / Near / Computer / Progressive / Bifocal

Reason for visit (check all that apply):
☐ Blurry vision (circle): Distance / Reading / Computer ☐ Double vision ☐ Flashes/floaters
☐ Dry Eyes ☐ Itchy Eyes ☐ Lost / Broke glasses ☐ Out of contacts

Do you or a family member have problems with any of the following (*check all that apply*)?

	SELF	FAMILY	SPECIFY *(e.g., Parents, siblings, grandparent. Please specify maternal or paternal)*		SELF	FAMILY	SPECIFY
Amblyopia (lazy eye)	☐	☐	___________	Diabetes	☐	☐	___________
Strabismus (eye turn)	☐	☐	___________	High Blood Pressure	☐	☐	___________
Glaucoma	☐	☐	___________	High Cholesterol	☐	☐	___________
Cataracts	☐	☐	___________	Thyroid Disease	☐	☐	___________
Macular Degeneration	☐	☐	___________	Autoimmune Disease	☐	☐	___________
Retinal Detachment	☐	☐	___________	Cancer	☐	☐	___________

Other Conditions: ______________________________

Any eye surgery or trauma?
☐ N / ☐ Y
Explain: ______________________

Are you pregnant or nursing?
☐ N / ☐ Y

Cigarettes/tobacco? ☐ N / ☐ Y Former ☐ Daily
Alcohol? ☐ N / ☐ Y Occasional Social ☐ Other

CURRENT MEDICATIONS AND DOSAGE:

DRUG ALLERGIES
- ☐ Penicillin
- ☐ Sulfa
- Other _____________

DRY EYE QUESTIONNAIRE

Do you experience any of the following symptoms?
☐ Burning ☐ Tearing/watering ☐ Stinging ☐ Redness
☐ Blurred vision ☐ Scratchiness ☐ Grittiness ☐ Irritation

CONTACT LENS HISTORY

Do you currently wear contact lenses? ☐ N / ☐ Y

If 'No', are you interested in wearing contact lenses? ☐ N / ☐ Y

What type of contact lenses do you wear (if applicable)? ☐ Soft ☐ Hard

Contact Lens Brand (if known): ____________________________________

How often do you replace your lenses? ☐ Daily ☐ 2 weeks ☐ Monthly

How many times a week do you wear your lenses? ___________________

Do you sleep in your lenses? ☐ N / ☐ Y

COMPUTER USE HISTORY

Hours on the computer per day? _________

Do you experience any of the following while using the computer?

- ☐ Eye strain
- ☐ Blurred vision
- ☐ Light sensitivity
- ☐ Eye fatigue
- ☐ Headaches
- ☐ Glare

Other (*please specify):* __________________

EMAILING & TEXTING

The Privacy Rule allows covered healthcare providers to communicate electronically, such as through email or text messages; with their patients, provided they apply reasonable safeguards when doing so. Please select and sign below which alternative mean(s) you allow Bell Vision Optometry to communicate with you:

☐ YES, I accept email and/or texting (and understand that charges may apply from my phone carrier) to receive updates and messages from Bell Vision Optometry. If so, please provide email and sign below.
If yes, please select an option from below:

- ☐ BOTH Email and Texting
- ☐ ONLY Email
- ☐ ONLY Texting

☐ NO, I decline email and texting and prefer that Bell Vision Optometry call me on the number(s) listed above to receive updates and messages. You may decline to input your email but please sign below.

Patient Email: ______________________

Patient Signature: ______________________ Date: __________

Parent / Legal Guardian Signature: ______________________ Date: __________

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

I understand and acknowledge that in an attempt to protect the privacy of my identifiable health information, Bell Vision Optometry has established a Notice of Privacy Practices. This information details the use and disclosure of information contained in my personal medical records kept for the purposes of diagnosis, treatment, payment and healthcare operations. In accordance with HIPAA Regulations, a copy of Bell Vision Optometry's Notice of Privacy Practices has been made available to me while in the facility today. Should I choose to have a personal copy, one will be given to me at no charge.

Patient Signature: ______________________ Date: __________

Parent / Legal Guardian Signature: ______________________ Date: __________

FINANCIAL AGREEMENT & CONSENT TO TREATMENT

The following contains important information concerning your financial responsibilities and your treatment at Bell Vision Optometry. **Please read it carefully.**

1. FINANCIAL AGREEMENT: I understand **payment for services is due in full at the time services are rendered**. Direct ship contact lenses must be paid in full at the time of order. Because services are based on medical necessity it is impossible for Bell Vision Optometry to provide a total cost prior to evaluation. I understand Bell Vision Optometry will bill my insurance as a courtesy, but this is not a guarantee that my insurance will pay for services rendered or materials provided. It is my responsibility to know my insurance benefits and coverage. **I am responsible for all copays, deductibles, and services or materials not covered by my insurance**. In the event that it becomes medically necessary for Bell Vision Optometry to enlist the services of a collection agency and/or legal assistance, I will be responsible for any allocation expenses and reasonable fees.

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Initial Here

2. NON-COVERED SERVICES: I understand that Bell Vision Optometry's agreements with health insurance plans (i.e., HMOs, PPOs) relates only to items and services which are "covered" by the insurance plan. **I accept financial responsibility for all items or services, which are determined by my insurance not to be covered, including the refraction fee.**

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Initial Here

3. MEDICARE: I request that payment of authorized Medicare benefits be made on my behalf to Bell Vision Optometry for services furnished to me by Bell Vision Optometry. I authorize any holder of medical information about me to release to the center for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services**. I understand my initials request that payment be made and authorizes release of medical information necessary to pay the claim. I also understand that I am responsible for the deductible, coinsurance and non-covered services**. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

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Initial Here

Authorization to Bill: I have read and understood the above information and agree to comply with these terms. I authorize my insurance company to make payment directly to Bell Vision Optometry for services and/or materials rendered. I authorize Bell Vision Optometry to release information about me or my dependents necessary to process any and all claims for reimbursement on my behalf.

Authorize to Treat: I also authorize Bell Vision Optometry, it's agents and employees, to furnish optometric care and services including but not limited to, diagnostic tests, examination and other medical and/or surgical procedures, which is deemed necessary in the course of my care.

Patient Full Name:

Patient or Parent / Guardian Signature: Date: