Bigley Eyecare Associates

Name: _____ Date of Birth: _____

Do you have vision insurance? ☐ Yes ☐ No, if yes name of carrier: _____

Do you have medical insurance? ☐ Yes ☐ No, if yes name of carrier: _____

Reason for today's exam: _____ Occupation: _____

Ocular History:
Please check any of the following that applies to you:

☐ Eye surgery ☐ Eye injury ☐ Cataract ☐ Macular degeneration ☐ Glaucoma

☐ Floaters/ spots ☐ Flashes ☐ Double vision ☐ Lazy Eye/ amblyopia ☐ Dry eye

Please describe all vision/eye issues: _____

_____

Health History:
Primary care doctor: _____ Endocrinologist (if applicable): _____

Please check any of the following that applies to you:

☐ Diabetes ☐ High blood pressure ☐ High cholesterol ☐ Heart condition

☐ Headaches ☐ Neurological problems ☐ Respiratory problems ☐ Arthritis

☐ Cancer ☐ Muscular/ joint problems ☐ Ear/ nose/ throat/ sinus ☐ Urinary problems

☐ Thyroid ☐Dermatology/ skin problems ☐ Gastrotinestinal probems ☐ Psychiatric conditions

☐ Pregnant ☐ Infectious disease ☐ Herpes simplex/ zoster ☐ Fever, weight loss, or gain

Describe the conditions above or any other health conditions:_____

_____

List all medications: _____

_____

List any family history of eye disease: _____

Any drug or food allergies: ☐ yes, ☐ no, if yes please list:_____

Do you use the following products:
Smoking/tobacco: ☐ yes, ☐ no, ☐ former smoker Alcohol : ☐ yes, ☐ no Recreational drugs: ☐ yes, ☐ no

Bigley Eyecare Associates

Name: _____ Date of Birth: _____

PERSONAL REPRESENTATIVE LIST

Please list below anyone (family members, caretakers, etc.) with whom you authorize the staff of Bigley Eyecare Associates to discuss your personal health information and/or financial charges. We may also contact these individuals in the event of an emergency. This list may be edited by you at any time.

Name: _____ Relationship: _____ Phone number: _____

Name: _____ Relationship: _____ Phone number: _____

Name: _____ Relationship: _____ Phone number: _____

Name: _____ Relationship: _____ Phone number: _____

CONSENT TO USE OF DISCLOSE HEALTH INFORMATION FOR TREATMENT AND HEALTH CARE OPERATIONS

Our Notice of Privacy Practices describes how health information about you may be used and disclosed and how you can gain access to this information. Please review it carefully. A copy of the notice is always available to you and can be provided at any time.

AUTHORIZATION

I authorize my insurance company (if applicable) to pay benefits directly to Bigley Eyecare Associates. I understand that my insurance carrier may pay less than the actual bill for services. I understand that it is my responsibility to pay the co-pay, deductible, and any other balance not paid by my insurance company. I agree to be responsible for payment of all services or products on behalf of myself or my dependents. I further assign Bigley Eyecare Associates all rights afforded to me under ERISA with respect to the services rendered including the right to bring an action to enforce ERISA and my ERISA rights. I agree my signature will be kept on file and authorize its use for processing of future insurance claims.

I have read the Notice of Privacy Practices of Bigley Eyecare Associates and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and health care operations.

Signature: _____ Date: _____

If you are signing as personal representative of the patient, list your name and describe your relationship to the patient.

Print name: _____Relationship to patient: _____