



Personal Information:

Name: _____ Married Single Date: _____

Preferred Name: _____ Gender: Male Female Date of Birth: _____

Address: _____
City State Zip Code

Phone: Home _____ Work _____ Cell _____

Email Address: _____ (We will only use your email for office communication/appointment information)

Employer: _____ Occupation: _____

Person Responsible for Account: _____ Whom may we thank for referring you? _____

Do you have any special needs? (for example: hearing-impaired, wheelchair access, etc...) _____

Do you drive? Yes No Primary Language: _____

Insurance Information:

Insurance Company: _____ SSN (last 4) XXX-XX- _____

Policy Holder's Name: _____ Policy Holder's Date of Birth: _____

Relationship to Patient: _____ Employer of Policy Holder: _____

Please Read & Sign:

I understand the insurance information I give is the information used to file my insurance claim and this is private information between the policy holder, the insurance company, and the employer. Therefore, I am responsible for checking my eligibility.

I understand that although Bass Lake Family Eye Care is a provider for most insurance companies, non payment can occur and it is then my responsibility to provide payment for services rendered.

I authorize payment of my medical/vision insurance benefits to Bass Lake Family Eye Care for services rendered and products purchased.

Signature: _____ Date: _____

HIPAA/Notice of Privacy Policy Acknowledgment:

This is a summary of how health information about you may be used. A full notice of your privacy rights will be provided upon request.

Bass Lake Family Eye Care uses health information about you for treatment, in obtaining payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive.

Bass Lake Family Eye Care will not disclose your information to others unless given permission or the law authorizes/requires us to do so.

Bass Lake Family Eye Care must maintain the privacy of protected health information, provide you with notice of its legal duties and privacy practices with respect to your health information, abide by the terms of the notice, notify you if it was unable to agree to the requested restriction on how your information is used or disclosed, accommodate reasonable requests you may make to communicate with health information by alternative means or by alternative locations and obtain your written authorization to use or disclose your health information for reasons other than those listed and permitted by law.

Signature: _____ Date: _____

Patient Health / Ocular History and Information:



Primary Care Clinic Name & Location: _____

Primary Doctor's Name: _____ Date of last physical exam: _____

Date & Location of Last Eye Exam: _____

Please list all prescribed and over the counter medications you are taking: _____

Please list all allergies you have (medication or environmental): _____

Do you currently wear: Glasses Yes No Contact Lenses Yes No

Have you or any family members been diagnosed with the following (if so please list relationship)?

- | | | | | | | | |
|--------------------------|------------------------------|-----------------------------|-------|----------------------|------------------------------|-----------------------------|-------|
| Glaucoma | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ | Autoimmune Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Cataract | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ | Cancer | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Macular Degeneration | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ | Diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Retinal Detachment | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ | Heart Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Color Blindness | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ | High Blood Pressure | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Amblyopia (lazy eye) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ | High Cholesterol | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Eye Injury/Surgery | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ | Kidney Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Eye Infection | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ | Neurological Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Strabismus (crossed eye) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ | Thyroid Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Blindness | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ | Other: | | | _____ |

Have you been experiencing any of these problems/conditions?

- | | |
|--|--|
| <input type="checkbox"/> Recent weight loss or gain | <input type="checkbox"/> Glare / Light Sensitivity |
| <input type="checkbox"/> Ear, nose, throat or sinus problems | <input type="checkbox"/> Tired Eyes |
| <input type="checkbox"/> Breathing problems | <input type="checkbox"/> Burning / Watery / Dry Eyes |
| <input type="checkbox"/> Digestive problems | <input type="checkbox"/> Eye Pain / Irritation |
| <input type="checkbox"/> Kidney/bladder problems | <input type="checkbox"/> Itchy Eyes |
| <input type="checkbox"/> Muscles, joint, bone problems | <input type="checkbox"/> Mucus Discharge |
| <input type="checkbox"/> Skin problems | <input type="checkbox"/> Droopy Lid |
| <input type="checkbox"/> Mental health problems (depression/anxiety) | <input type="checkbox"/> Redness |
| <input type="checkbox"/> Blood/lymph problems | <input type="checkbox"/> Blurred Vision |
| <input type="checkbox"/> Chronic headaches | <input type="checkbox"/> Double Vision |
| | <input type="checkbox"/> Floaters / Flashes of light |
| | <input type="checkbox"/> Loss of Vision |

Are you pregnant or nursing: Yes No

Social History: (this information is kept confidential, however you may discuss this portion with the doctor directly if you prefer)

Do you use any of the following:

- Alcohol? Yes No Type, amount, how long: _____
- Tobacco? Yes No Type, amount, how long: _____
- Recreational drugs? Yes No Type, amount, how long: _____

Please indicate your race/ethnicity:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> White | <input type="checkbox"/> Black/African American | <input type="checkbox"/> Asian | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> American Indian | <input type="checkbox"/> Native Hawaiian/ Pacific Islander | <input type="checkbox"/> Hispanic/Latino | <input type="checkbox"/> Decline to Answer |

Signature: _____ **Date:** _____

Initial: _____ Date: _____ Initial: _____ Date: _____ Initial: _____ Date: _____

Initial: _____ Date: _____ Initial: _____ Date: _____ Initial: _____ Date: _____