Bellaire • Welcome to our Office • Champions

Full Name ______________________
Nickname ______________________
Address ______________________
City ____________ State _____ Zip ______
Date of Birth ____________ Age ____ Sex: M F
Employer/School ______________________
Occupation/Grade ______________________
Spouse (or Parent's) Name ______________________
Children's Names & Ages ______________________
SS# ____________ Work Ph ____________
Home Ph ____________ Cell Ph ____________
May we contact you by: ____ Home # ____ Office #
____ Cell# ____Text ____ E-mail
E-mail Address ______________________

Today's Date ______________________
What is the primary purpose of today's visit? ______________________

Last Vision Exam: ______________________
Office/Doctor: ______________________

Current Medications (Rx or Over the counter)

1. 4.
2. 5.
3. 6.

Current Vitamins or Nutritional Supplements

1. 3.
2. 4.

Allergies to Medications? Y / N

If so, please list:

1. 3.
2. 4.

IF YOU ARE A NEW PATIENT, PLEASE COMPLETE BELOW.

Personal and Family History (parent, grandparent, sibling, children) Please check any of the following for which you or a family member has a history. List relationship and specifics below.

	Self	Family		Self	Family
Retinal Disease	☐	☐	Eye Surgery	☐	☐
Glaucoma	☐	☐	Thyroid	☐	☐
Cataracts	☐	☐	Arthritis	☐	☐
Macular Degeneration	☐	☐	Systemic Lupus	☐	☐
Strabismus/Crossed Eye	☐	☐	Multiple Sclerosis	☐	☐
Amblyopia / Lazy Eye	☐	☐	Diabetes	☐	☐
ADD/ADHD	☐	☐	Heart Disease	☐	☐
Learning Disability / Dyslexia	☐	☐	High Blood Pressure	☐	☐
Autism/PPD	☐	☐	Migraines	☐	☐
Sensory Integration Issues	☐	☐	Seizure Disorder	☐	☐

Other Medical Conditions ______________________
Current State of Health ☐ Excellent ☐ Good ☐ Fair ☐ Poor

How did you choose our office for your eye care?

☐ Family / Friend Referral ______________________
☐ Professional Referral ______________________
☐ Insurance Provider List ______________________
☐ Advertisement In ______________________
☐ Website ______________________

Do You…

Currently wear glasses? Y N For: ____________
Currently wear contacts? Y N
If so, what kind ____________
Replacement Schedule ____________

Are You…

Interested in wearing contacts? Y N
Interested in Laser Vision Correction? Y N

Do You…

Play Competitive Sports? Y N
Type(s) ____________
Position(s) ____________
Work on the computer more than 4 hrs/day? Y N
Perform other nearwork more than 4 hrs/day? Y N

Do you experience…

☐ Redness
☐ Spots / Floaters
☐ Flashes of light
☐ Double vision
☐ Blurry distance vision
☐ Blurry near vision
☐ Sudden loss of vision
☐ Discomfort in Glasses
☐ Discomfort in Contacts
☐ Glare or Reflection
☐ Tearing / Burning
☐ Dryness
☐ Eye Strain
☐ Soreness of eyes
☐ Tinnitus/Ears Ringing
☐ Itchy Eyes
☐ Headaches
☐ Nausea
☐ Dizziness / Imbalance
☐ Sensitivity to sounds
☐ Carsickness
☐ Fatigue when reading
☐ Inattentiveness
☐ Poor Night Vision
☐ Lack of coordination
☐ Difficulty after Car Accident
☐ Flicker Sensitivity
☐ Trouble walking up or down stairs
☐ Light Sensitivity
☐ Other

Child's Developmental History

CHILD'S NAME ______________________ BIRTHDATE ___/___/____ AGE: _______
NICKNAME ________________________ HOME PHONE ____________________
FATHER'S NAME ____________________ DAYTIME PHONE __________________
MOTHER'S NAME ___________________ DAYTIME PHONE __________________
SIBLINGS NAMES AND AGES ____
____

DEVELOPMENTAL & BEHAVIORAL HISTORY

1. Full term pregnancy? ____________________ Normal birth? ____________________
2. Was there anything unusual about your child's early development? __________________
3. At what age did your child first talk? _______________________________________
4. Any speech difficulties now? ____
5. First walked alone at what age? ____
6. Hand preference was clearly indicated at what age? _________R or L or Both (please circle)
7. Are there any indications of hearing problems? _________________________________
8. Have there been any significant injuries to your child's head or eyes? ________________
9. Has a neurological, psychological, speech, or hearing evaluation been performed in the past?

	TYPE OF EVALUATION	DATE	BY WHOM	DIAGNOSIS
1.				
2.				
3.				

ACADEMIC HISTORY

NAME OF SCHOOL ______________________________ CURRENT GRADE ________

1. Does your child like school? ________Like teacher? _______Any grades repeated? _______
2. Have there been any school difficulties? ______________________________________
3. Child's favorite subjects? ____
4. Child's most difficult subject areas? ____

VISUAL SYMPTOMS AND OBSERVATIONS	YES	NO
1. Vision is blurry at any time	____	____
2. Child sees double at any time	____	____
3. Complains of fatigue with reading	____	____
4. Confusion of similar words or letters	____	____
5. Reversals of words or letters when reading or writing	____	____
6. Poor comprehension	____	____
7. Dislikes reading but likes being read to	____	____
8. Rubs eyes during or after reading	____	____
9. Closes or covers one eye	____	____
10. Headaches when reading	____	____
11. Holds head too close to desk when writing	____	____
12. Difficulty copying from chalkboard or book	____	____
13. Neatness of writing is a problem	____	____
14. Slow with written work	____	____
15. Dislikes tasks requiring sustained visual concentration	____	____

Bellaire Family Eye Care

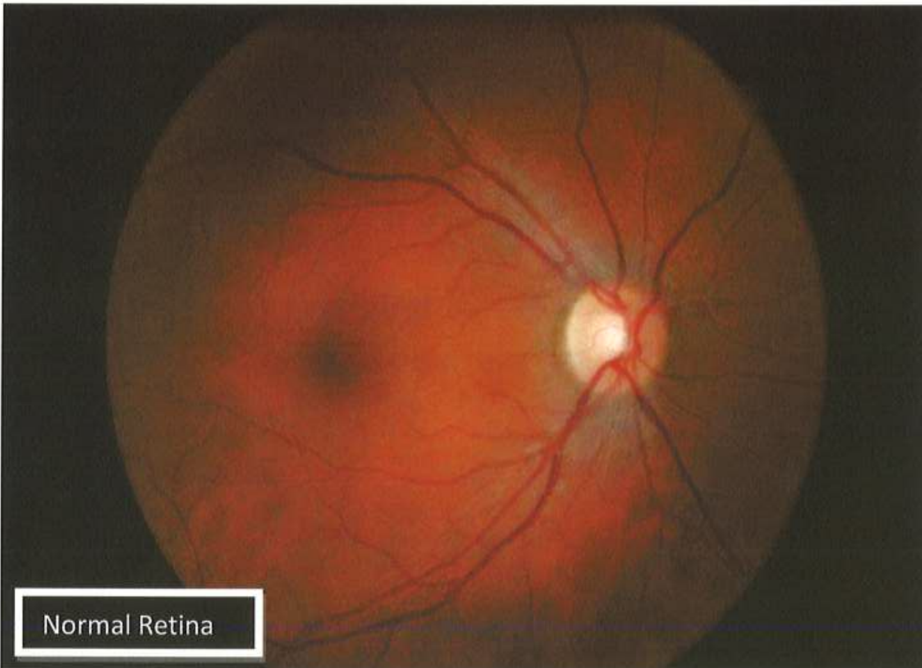
Photographic Retinal Examination

We at Bellaire Family Eye Care are pleased to provide our patients with an advanced digital photograph of your retina.

The Retinal Photographic Evaluation Includes:

- ☐ A copy of your retinal photo to take home
- ☐ An in depth view of the retinal surface
- ☐ A permanent record for your medical file, for serial analysis, comparisons, and diagnosis

Since insurance may not pay for this evaluation, this is an out of pocket expense. <u>There is an additional cost of $35.00 to the basic eye exam you are receiving today</u>.



☐ **I AGREE TO** have my retinal health evaluated with the Retinal Photographic Exam.

☐ **I DO NOT** wish to have the Retinal Photographic Exam. I understand that I will still have a thorough eye examination with slit lamp observation.

______________________________ __________________

Patient/Guardian's Signature Date

Bellaire Family Eye Care
Notice of Privacy Practices

Our office is required by law to maintain the privacy of your heath information and to provide you with this notice. It describes how your health information can be used and disclosed and how you can access this information.

We will only use and share your health information for the purpose of providing treatment for you and your family or obtaining payment. Your health information will not be used for any other purpose unless we have asked for and been given your written permission.

We promise to use your health information within our office to provide you with the best possible care. This may include office procedures designed to optimize the coordination of the care between the doctors, the technicians, and office staff. In addition, we may share information with referring physicians, pharmacies, and other health care professionals providing your treatment. We may share your information with a family member or friend who is involved in your medical care or payment for your care, provided that you agree to the disclosure, or we give you an opportunity to object to the disclosure.

Because we believe regular exams are crucial to maintaining the health of your eyes, we will send out reminders when its time to schedule an appointment. We may also contact you to follow up on your care and to inform you of new treatments or services that may be of interest to you and your family. These communications are an important part of our commitment to you and provide the best eye care possible.

Under the new HIPAA (Health Insurance Portability and Accountability Act) laws, patients have certain rights related to your health information. You have the right to restrict the uses and disclosure of your information. You have the right to request that we only communicate with you privately. You have the right to read, review, and copy your information. If you would like a copy of the right to complain to our office or to the Secretary of Health and Human Services, or if you believe your privacy have been compromised by this office, please express your request or concerns to us in writing.

Other than the procedures stated above, or where required by Federal, state, or local law, we will not disclose your health information without your written authorization. You may revoke that authorization in writing at any time.

Acknowledgment of Privacy Practices

I acknowledge that I have read and understand the privacy practices of this office.

Signed____Date__________

Bellaire Family Eye Care
Financial Policy

We are dedicated to providing you with the best possible care and service, and regard your understanding of our financial policies as an essential element of your care and treatment. To assist you, we have the following financial policy. If you have any questions, please feel free to discuss them with our staff.

Payment is due at the time of service. For your convenience we accept VISA, Master Card, Discover, American Express or Debit Card.

Using Insurance for Services @ Bellaire Family Eye Care Suite # 107: We have made prior arrangements with many insurers and other health plans. We will bill those plans with which we have an agreement and will collect any required co payment at the time of service. In the event your health plan determines a service to be "not covered", you will be responsible for the complete charge. In that event we will bill you, and payment is due upon receipt of that statement.

If you have insurance coverage with a plan with which we do not have a prior agreement, payment is due at time of service. We will provide you with a Super Bill for you to file.

Minor Patients: For all services provided to a minor, the adult accompanying the patient is responsible for payment.

Services from our Vision Learning Center Suite # 102:
Our Vision Learning Center (Suite #102) is a **Self Pay Clinic. We do not file any insurances** and payment is due at time of services.

Missed Appointments: In order to provide the best possible service and availability to all our patients, it is our policy to require 24 hour notice to cancel an appointment. At the time of cancellation you can go ahead and reschedule a make-up date.

I have read and understand the financial policy of Bellaire Family Eye Care and the Vision Learning Center and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

____ __________
Signature of Patient or Responsible Party if a Minor Date

______________________________ ______________________________
Signature of Co-responsible Party Name of Patient: