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

Bellaire Family Eye Care
Notice of Privacy Practices

Our office is required by law to maintain the privacy of your health 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 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 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 HIPPA (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 has 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.

Acknowledgement 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 documentation 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 the time of services.

Missed Appointments: In order to provide the best possible care and availability to all our patients, it is our policy to require 24 hour notice to cancel any appointment. At the time of cancellation you can 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 Part Name of Patient