# WELCOME

Patient Name: ______________________________________ Age: _____ Gender: _____ Date: ____________

Social Security Number: _______________________ Work Phone: _______________ Birthdate: ___________

Employer: _______________________________ Occupation: _____________________________

Home Address: __________________________________________________________________

City State Zip

Phone: Home: _____________________________ Cell: ________________________________

Whom may we thank for referring you to us? ___________________________________________

Have we seen any other members of your family? □ Yes □ No If so, whom? _______________

_________________________________________________________________________________

Please check your status:

- □ Married
- □ Single
- □ Separated
- □ Divorced
- □ Partnered
- □ Minor

Date of last eye exam: ________________ Name of eye doctor: _________________________

Date of last medical exam: ______________ Name of medical doctor: __________________________

Who should we contact in case of an emergency? _____________________________________________

Emergency contact's phone number: _______________________________________________________

** If patient is a minor:

Responsible party name: ______________________________ Relationship: ______________________

**INSURANCE INFORMATION and FINANCIAL ARRANGEMENTS**

Primary MEDICAL insurance carrier name:_____________________________________________

Policy holder's name:_________________________ Date of Birth:_______________________________

Policy holder's social security number: ____________________________________________________

VISION insurance carrier name: ________________________________________________________

Policy holder's name: ________________________ Date of Birth: _______________________________

Policy holder's social security number: ____________________________________________________

I hereby authorize Drs. Becvar/Becvar Optometry to furnish information to insurance carriers concerning my illness and treatment, and I hereby assign to the physician all payments for medical services rendered to myself or dependents. I understand that I am responsible for any amounts not covered or paid by insurance.

**Late Fees**: If I do not pay the entire amount due within 25 days of the monthly billing date, late charges will be added of 1.5% to the unpaid balance. If the unpaid balance is forwarded to our collection agency, a collection fee of 45% will be added to the unpaid balance to cover collection costs.

**Returned Checks**: Any returned check will be assessed a $25 fee.

Signature: ______________________________________________ Date: ______________________

**HIPAA**

I have reviewed or received a copy of Becvar Optometry's Health Insurance Portability and Accountability Act. (HIPAA) By signing below I authorize the disclosure of my health information as described in the form.

Signature: ______________________________________________ Date: ______________________

# HEALTH HISTORY

Patient Name: ________________________________________ Date: __________________________

♦ Please check any condition that applies to **yourself or any member of your family** (parents, grandparents, siblings, children; living or deceased):

| | Self | Family | | Self | Family |
|---|---|---|---|---|---|
| Cancer | ___ | ___ | Glaucoma | ___ | ___ |
| Diabetes | ___ | ___ | Lazy eye | ___ | ___ |
| Heart Disease | ___ | ___ | Macular Degeneration | ___ | ___ |
| High Blood Pressure | ___ | ___ | Retinal Detachment | ___ | ___ |
| Other general health problems | ___ | ___ | Retinitis Pigmentosa | ___ | ___ |
| Blindness | ___ | ___ | Other eye condition | ___ | ___ |
| Cataracts | ___ | ___ | | | |

♦ Have **you** experienced or have you been diagnosed with any of the following?

| Yes | No | | Yes | No | |
|---|---|---|---|---|---|
| □ | □ | Fever, weight loss/gain | □ | □ | Kidney/Bladder disorder |
| □ | □ | Headaches | □ | □ | Arthritis |
| □ | □ | Migraines | □ | □ | Anemia |
| □ | □ | Seizures | □ | □ | HIV/AIDS |
| □ | □ | Thyroid condition | □ | □ | Anxiety |
| □ | □ | Asthma | □ | □ | Depression |
| □ | □ | Emphysema | □ | □ | Other medical conditions: _______________ |

♦ Do you smoke or use tobacco? □ Yes □ No

♦ Do you drink alcohol? □ Yes □ No

♦ (Females only) Are you: Pregnant? □ Yes □ No Nursing? □ Yes □ No

♦ List type and date of prior surgeries (including eye surgeries): ______________________________

_________________________________________________________________________________

♦ Do you have any environmental/seasonal allergies? □ Yes □ No If yes, please check the following eye-related allergy symptoms you experience: __ itching __ burning __ redness __ watering

♦ Please list all **medications** you are currently taking:

________________________________________

________________________________________

________________________________________

________________________________________

♦ Please list all medications you are **allergic** to:

________________________________________

________________________________________

________________________________________

________________________________________

♦ **Ocular History** -Please check all of the symptoms that apply to **you**:

| Yes | No | | Yes | No | |
|---|---|---|---|---|---|
| □ | □ | Blurred vision - distance | □ | □ | Eyestrain |
| □ | □ | Blurred vision - near | □ | □ | Floaters (spots) |
| □ | □ | Double vision | □ | □ | Flashes of lights |
| □ | □ | Dry eyes | □ | □ | Light sensitive |
| □ | □ | Eye infection | □ | □ | Burning eyes |
| □ | □ | Eye injury | □ | □ | Watery eyes |

Are you interested in laser eye surgery? □ Yes □ No

Do you wear contact lenses now? □ Yes □ No

Are you interested in wearing contacts? □ Yes □ No

If yes, are you interested in:

colored contacts □ Yes □ No

sleeping in your contacts □ Yes □ No

Do you wear glasses? □ Yes □ No

Do you work on a computer? □ Yes □ No

Do you have trouble with glare? □ Yes □ No

Please list hobbies/sports you participate in:

________________________________________

________________________________________