PATIENT INFORMATION

PATIENT NAME: _____ **SEX: M F**
LAST FIRST M.I. NICKNAME

ADDRESS: _____ **Apt No:** _____

_____ **BIRTHDATE:** ____/____/_____
CITY STATE ZIP

E-MAIL: _____ **HOME PHONE:** _____

WORK PHONE: _____ **CELL PHONE:** _____

SOCIAL SECURITY #: _____ **MARITAL STATUS: (Circle One) M S D W**

PRIMARY LANGUAGE: _____ **HISPANIC/LATINO: Yes ____ No____**

RACE: (Circle One) WHITE AFRICAN-AMERICAN NATIVE-AMERICAN ASIAN HAWAIIAN/PACIFIC ISLANDER OTHER _____

Primary care doctor: _____

Who referred you to our practice? _____

Who else can we speak with regarding your medical records (Give full name(s)): _____

_____

I understand that my vision insurance cannot be billed if I am diagnosed with a medical condition and instead will be billed under my medical insurance. I will be responsible for co-payments, co-insurance and deductible amounts.

Our refraction fee is $40.00. Payment due at time of service.

Signature: _____

PLEASE COMPLETE ONLY IF DIFFERENT THAN PATIENT:

INSURANCE POLICYHOLDER: _____
LAST FIRST M.I. RELATIONSHIP

____/____/_____ _____-_____-_____
BIRTHDATE SOCIAL SECURITY #

PERSON RESPONSIBLE FOR ACCOUNT: _____
LAST FIRST M.I.

ADDRESS: _____

RELATION TO PATIENT: _____ **PHONE NUMBER:** _____

MEDICAL HISTORY QUESTIONNAIRE

Patient Name: _____ Birthdate: ____/____/____ Date: ___/____/____

REASON FOR VISIT (Circle All That Apply):

___Medical: (We will bill your **Medical Insurance** if you have one)

Circle All That Apply:

Cataract Diabetes Glaucoma Macular Degeneration Floaters Dry Eye Infection Injury Allergy Irritation Foreign Body Other:_____

Diabetics: Last A1c: _____ (or Last Blood Sugar _____) Date of A1c: ___/___/_____

Date Diagnosed with Diabetes: ___/___/_____

___Vision

Circle All That Apply:

Glasses Prescription (some insurances and Medicare, **WILL NOT PAY FOR THIS SERVICE**) The charge for this is $40.00 and is due at the time of service.

Contact Lens Prescription (some insurances and Medicare, **WILL NOT PAY FOR THIS SERVICE**) The charge for this ranges from $40.00 - $120.00 and is due at the time of service.

___Driver's License Form (this requires a specialized peripheral vision test and is **NOT** covered by any insurance). The charge for this test and form completion is $110 and due at the time of service. This is in addition to any other copay/coinsurance/deductible amounts.

Dilated Eye Exam

Routine, undilated retinal exams provide only a limited, narrow-field view of the retina (typically up to about 45 degrees or 5% of the retina). These exams can miss disease or conditions that may be present in the periphery of the retina. FEC dba Bluegrass Eyecare Center recommends that **ALL** patients have their eyes dilated:

___ I understand the benefits of dilation and I **DO** agree to be dilated.

___ I have read and understand the benefits of dilation, but I **REFUSE** to have my eyes dilated today.

Past or Present Eye Problems (Check All That Apply):

SURGERIES (Check all that apply):

Procedure (Eye)	Surgeon	Date	Procedure	Surgeon	Date
____Cataract (R/L)	_____		____Cosmetic	_____	
____LASIK/ PRK (R/L)	_____		____Other	_____	
____Glaucoma (R/L)	_____		____Eye Muscle (R/L)	_____	
____Retina (R/L)	_____				

	Past or Present Eye Problems	Family History (Mother, Father, Child)
Glaucoma	____	_____
Cataracts	____	_____
Macular Degeneration	____	_____
Eye Injury	____	_____
Retinal Disease	____	_____
Loss of Eye	____	_____
Blindness	____	_____
Eye Muscle Problems	____	_____
Amblyopia/Lazy Eye	____	_____
Dry Eye	____	_____
Diabetes	____	_____

REVIEW OF SYSTEMS: Do you have any problem in the following areas? **Check all that apply**:

Constitution
____Bleeding Problems
____Headaches
____Seizures
____Weight Loss

Cardiovascular
____Bypass Surgery
____Heart Stents
____Heart Attack
____Pacemaker
____Hypertension
____ Heart Murmur
____ High Cholesterol
____ Irregular Heart Beat
____ Heart Valve Problem
____ Stroke

Respiratory
____ Asthma
____ COPD
____ Lung Cancer
____ Pneumonia
____ Sarcoid
____ TB

GI
____Reflux (GERD)
____ Hernia
____ Gallbladder
____ Hepatitis

GU
____Bladder
____Kidney
____Prostate
____Urinary

Musculoskeletal
____Arthritis
____Cerebal Palsy
____MS
____Rheumatoid Arthritis

Integumentary
____Basal cell
____Dermatitis
____Rosacea
____

Neurologic
____Bells Palsy
____Dizziness
____Migraine
____TIA

Psychiatric
____Depression
____Dementia
____Anxiety

Endocrine
____Diabetes
____Thyroid
____

Blood/Lymphatic
____Anemia
____Hemophilia
____Leukemia
____HIV

Smoking History:
Check One:
____ Daily Smoker
____ Former Smoker
____ Never Smoked

Tobacco Users Check One
____Cigarettes
____Cigar
____Vape

Alcohol History
Check One:
____Non Drinker
____ Social Drinker
____ Daily Drinker

Do you use Recreational Drugs (Circle One): ____Yes ____ No **If yes**, type used: _____

List current medications, OTC and supplements you take:

Name of Current Medication	Taken for what condition	Dosage	Frequency

Allergies (Check all that apply):

____ Penicillin
____ Aspirin
____ Codeine
____ Erythromycin
____Fluorescein
____Sulfa
____Tetracycline
____Dairy Products
____Cipro
____Bactrim
____Thimerosal
____LATEX
___ Other: Please list
_____
_____
_____

Pharmacy: _____
Name Address

Females: Please check if pregnant: _____YES _____ NO

Patient Name: _____ Date: _____

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Portability and Accountability Act of 1996 (HIPAA). Revised 9/2013.

The patient understands the following:

Protected health information may be disclosed or used for treatment, payment or health care operations
The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
The Practice reserves the right to change the Notice of Privacy Policies
The patient has the right to restrict the uses of their information, but the Practice does not have to agree to those restrictions
The patient may revoke this Consent in writing at any time and all future disclosures will then cease
The Practice may condition treatment upon the execution of this Consent.

Patient signature: _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN AND RELEASE INFORMATION/ADVANCE BENEFICIARY NOTICE OF NON-COVERAGE

I _____ hereby authorize release of any medical information necessary to process this claim and request that payments of assigned benefits be made to Frankfort Eye Center, DBA Bluegrass Eyecare Center (C. Richard Bowers, Jr., M.D., Irfan Ansari, M.D., Marsha K. Penn, M.D, Daniel Good, M.D.,, Khalil Harbie, M.D., Kenneth Weaver M.D., Anthony Bisotti, O.D. and Jeremy Smith,O.D.)
Please be advised that Medicare, Medicare Replacements, and many insurance companies do not consider an eye refraction test to be medically necessary and therefore deny payment for this service. (Section 1862 (a) (7). **The refraction test, also called eye test or vision test, is a procedure performed to determine the prescription for eyeglasses or contact lenses. The refraction will show if lenses will improve your vision. If you have a refraction test for glasses, the fee is $40.00 in addition to any co-pays, deductibles, or other non-covered medical services**. If overpayment on services is collected, we will issue a refund in the same form of payment. If you pay with a credit card and need a refund via check, there will be a processing fee deducted from the refund.

Payment is DUE at time of service. We accept cash, check or credit card.

Purchases in the optical shop are non-refundable. All optical sales are final.

I understand that I am financially responsible for all charges whether or not paid by said insurance company. A copy of this statement shall remain on file for all future treatments and claims.

Signature: _____
Date: _____