YEAR: 2018

Brief History Questionnaire

Name: ______________________ Today's Date: ____/____/____

Address: ______________________ City: __________ Zip: __________

Home Phone: ______________________ Work Phone: ______________________

E-Mail Address: ______________________ Occupation: ______________________

Guardian (if applicable): ______________________ Employer/Company: ______________________

Social Security # ____-____-____ Birth Date: ____/____/____

Name of Medical Doctor: ______________________ Dr.'s Phone Number: ______________________

Do you have any children? ☐ Yes ☐ No Last Eye Exam: ____/____/____

Were you referred to our office? ☐ No ☐ Yes If yes, referred by: ______________________

Are you interested in information about Lasik (Laser Vision Correction)? ☐ No ☐ Yes

Do you wear glasses? ☐ No ☐ Yes If yes, how old is your present pair of lenses? ______________________

Do you use tobacco products? ☐ Yes ☐ No

Do you have any medications for? ☐ **High Blood Pressure** ☐ **Cholesterol** ☐ **Diabetes**

Are you pregnant and/or nursing? ☐ No ☐ Yes

Circle any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections/injuries/surgeries: ______________________

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I have been given Bellmawr Eye Care, LLC's Notice of Privacy Practices. I have read and understand this form.

Patient Signature ______________________

Financial Policies and Patient Responsibility:

Bellmawr Eye Care, LLC does its best to accurately obtain your coverage and charge you in accordance to your insurance benefits. While we will do everything we can to keep you informed of covered vs. non-covered services. Final determination of coverage and payment is not made until your insurance claim is reviewed by your insurance company. **In cases where professional goods and services are not covered (therefore, denied) by your insurance company, it will be the patient’s responsibility to pay for these services in full.** Claims not paid due to errant or undisclosed insurance information provided by the patient will be the responsibility of the patient as well. If we are not on your insurance plan, we require full payment for all services and products at the time they are rendered, but will provide you with an itemized receipt that you may submit to your insurance plan for potential reimbursement. I have read and understand the financial policy of Bellmawr Eye Care, LLC and I do accept financial responsibility:

Initial __________

Vision vs. Medical Insurance and Assignment of Insurance Benefits:

Vision insurance coverage is designed to cover routine eye services and to determine a glasses and/or contact lens prescription. When a medical condition or diagnosis is present, it may be necessary to file your examination to your medical insurance. Many times, we may not be aware of any medical diagnosis beforehand. These rules are often dictated by the insurance carriers themselves. Should this situation arise, we will do our best to inform you as to whether we will file your examination to your vision or medical insurance. **In either case, the patient is responsible for any financial responsibility as dictated by their respective insurance company.**

Initial __________

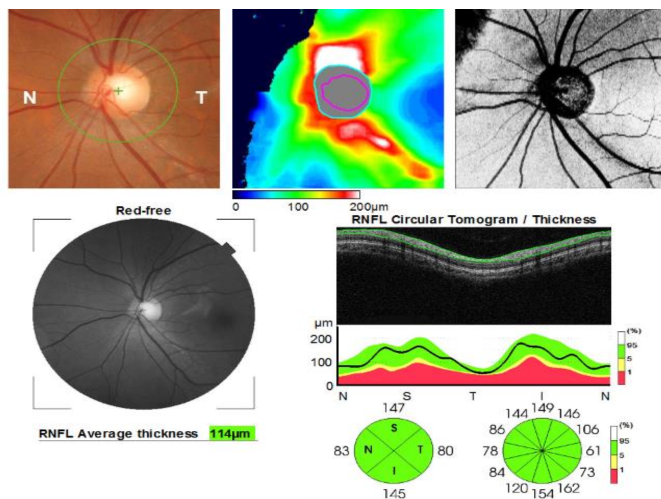
OPTICAL COHERENCE TOPOGRAPHY (OCT)

The *Topcon* ***Maestro 3D OCT-1*** Optical Coherence Tomography (OCT) is a diagnostic tool that is used at Wills Eye Hospital and all top-rated eye specialists. It is the **most advanced screening possible** for analyzing the health of your eyes. The OCT is a **digital photograph combined with a scan beneath the surface of the retina.**

This important screening is ***strongly recommended by the doctor*** and assists in **the early detection of many disorders of the eye and body.**

The OCT screening is especially important for people who have not had this done in order to have a baseline, and for people who have the following:

- See spots or flashes of light
- A history of diabetes
- A history of high blood pressure
- Circulatory problems
- A strong eyeglass prescription
- Glaucoma suspect
- Macular degeneration suspect
- Signs of stroke/cancer/tumors



There is a charge of **$40.00** for the digital imaging which is **not covered by insurance**.

Please check the appropriate line below.

_________ **YES** I want the screening _________ **NO** I do not want the screening

Patient Signature: ________________________________ Date: _________________

Contact Lens Evaluation

A contact lens prescription is separate from the eyeglass prescription, therefore, there is an additional charge for this service ($40-$89). An evaluation is necessary to ensure the lenses are fitting both eyes properly and that the health of the eyes is not harmed by the contact lenses. Contact lens prescriptions are valid for 1 year from the date of the evaluation.

_________ **YES** I want the evaluation _________ **NO** I do not want the evaluation

Patient Signature: ________________________________ Date: _________________