BERRY STEWART EYE CENTER

Patient Demographics and Medical History

Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Age	Social Security #

Preferred Contact Number	Alternate Contact Number	Email Address

Address	City	Zip	State

Emergency Contact	Phone	Are you on Hospice? Yes / No If yes, provide Medicare ID	Medicare Member ID #

Do you have an active Power of Attorney? Yes / No

POA Name:_____Phone#_____

Release of Information & HIPAA Acknowledgement

I hereby authorize Berry Stewart Eye Center to 1) Release any information necessary to insurance carriers regarding my illness and treatments; 2) To process insurance claims generated in the course of the examination or treatment; and 3) to allow a photocopy of my signature to be used to process insurance claims.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are required to abide by the terms of the notice currently in effect. Please note that by signing the Acknowledgment Form you are acknowledging that you have read or received a copy of our Notice of Privacy Practices issued by **Berry Stewart Eye Center**.

Please allow the following person access to my records; to call on my behalf regarding appointments, insurance, medical history etc. (This will remain the same unless updated information is provided by the patient)

Name	Phone Number	Relationship
Name	Phone Number	Relationship

Signature: _____ Date:_____

Financial Responsibility & Assignment of Benefits

I have read, acknowledge and understand that any charges **NOT** covered by my insurance company, as well as any applicable co-payments and deductibles are my responsibility. All Professional services rendered and charged at the time of service, are due **AT THE TIME OF SERVICE**, unless other arrangements have been made in advance by either the patient or the insurance carrier.

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled, and authorize and direct my insurance carrier(s), including Medicare, Private Insurance, and any other health/medical plan, to issue payment checks directly to **Berry Stewart Eye Center** for medical services rendered to myself and/or dependents.

Signature: _____ Date:_____

Billing Policy for Glasses Prescription (Refraction)

Your signature below states that you understand that if you are refracted you are responsible for the refraction charge. A “refraction” is a measurement of the lens power necessary to prescribe glasses or other corrective lenses. This procedure is not covered by most medical insurance plans including Medicare.

The fee for refraction is $40.00 and is due at the time of service.

Signature: _____ Date:_____

Reason for visit today: _____

_____

Ocular History

Have you ever been diagnosed with any eye condition/disease? If yes, please check and list the date of diagnosis.

□ Cataracts _____ **□ Macular Degeneration _____**

□ Dry Eyes _____ **□ Retinal Detachment _____**

□ Glaucoma _____ **□ Other _____**

Have you had any eye surgeries? If yes, please list the type of surgery, date of surgery, and the name of the surgeon.

_____

_____

Current Medical Conditions

None_____

(Please list Date began, if known)

Condition	Date	Condition	Date	Condition	Date
High Blood Pressure		Blood Clots		Rosacea	
Stroke		Leg/Muscle Cramps		Sleep Apnea	
Cholesterol		Anemia		Asthma	
Heart Disease		HIV/AIDS		Menopause	
Hearing Loss		Sarcoidosis		Migraines	
Sinus Problems		Shingles		Headaches	
Renal Disease		Cold Sores/Fever Blisters		Graves Disease	
Hepatitis		Crohn's		Dementia	
Acid Reflux		Raynaud's Disease		Alzheimer's	
Anxiety		Weight Changes		Memory Loss	
Diabetes Mellitus Type		Diabetes Last A1C		Thyroid Disorder Hyper / Hypo	
Cancer Type		Lupus Liver DS		COPD Are you on a CPAP	Y N
Arthritis		Rheumatoid Arthritis		Osteoporosis	
Seizures		Prostate Disorder Have you ever taken Flomax or Tamsulosin?	Y N	Other Other:	

Have you had any surgeries? If yes, please list the type of surgery, date of surgery, and the name of the surgeon.

_____

_____

Family History

Adopted_____ **No Family History_____**

Family Members	Diabetes	Glaucoma	Macular Degeneration	Hypertension
Mother				
Father				
Sister				
Brother				
Aunt/Uncle				
Mat. Grandmother				
Mat. Grandfather				
Pat. Grandmother				
Pat. Grandfather				

Have you ever Smoked? □ Yes □ No When did you quit?_____
Do you drink alcohol? □ Yes □ No If yes, how many drinks do you have in a typical day?___
Who Referred you to this office? _____

Health Care Professionals	Doctors Name	Phone Number
Primary Care Physician		
Optometrist		
Endocrinologist		
Neurologist		
Rheumatologist		
Cardiologist		
Other:		

Eye Drops	Eye	Dosage

Local Pharmacy:_____
Mail Order:_____
Height:_____ **Weight:_____**
Drug Allergies:_____

Medication	