Date:____________________ Chart #: ________________________ Provider Name:________________________
Name:___________________________________ Nick Name:_______________ DOB ______________ SS #:_____________
Address:________________________________________ City:____________________ State:_______________ Zip: _____________
Home #:(_______)_________________ Day #: (_____)_________________ Cell #:(________)___________ [ ] Texting OK

**For Office Use**

Exam [ ]New [ ]Recall Refraction[ ] CL Exam [ ]New [ ]Recall CL Fit/Dispensing[ ] CL FollowUp/Check[ ] OV [ ] Red Eye[ ] Foreign Body[ ]
Exam CoPay $ CLs CoPay $ Materials CoPay$ Disc Eligible: [ ] Exam [ ] Materials

**Patient Information**

| Race | | Ethnicity | Sex | Preferred Communication | | Preferred Language |
|---|---|---|---|---|---|---|
| [ ] American Indian | [ ] Asian | [ ] Hispanic or Latino | [ ] Male | [ ] Telephone | [ ] Email | [ ] English |
| [ ] African American | [ ] Hawaiian | [ ] Non-Hispanic or Latino | [ ] Female | [ ] Cell Phone | [ ] Postal | [ ] Spanish |
| [ ] White | [ ] Decline to Specify | [ ] Decline to Specify | [ ] Decline to Specify | | | [ ] Other |

Spouse:________________________________________ If under 18 years of age, legal guardian:____________________________
Have we seen anyone from your family before? [ ] Y [ ] N If yes, whom? _____________________________________________
Confidential Email:_________________________________________________________________________________________
Occupation:_______________________________________ Employer:________________________ City:________________ St:________
Emergency Phone Number: (______)___________________ Date of last eye exam:______________ Dilated: [ ] Y [ ] N
Name of family doctor:________________________________ Phone #:(_______)_____________ Fax #:(_______)_____________

**Responsible Party and/or Insurance Cardholder should complete the section below**

Guarantor/Insurance Primary Card Holder:___________________________________________________________
DOB:_________________________________________ SS#:____________________________*(Required to file all insurance)*
Relationship to Patient:____________________________________________________________
Insurance Plan:_________________________________ Employer:_________________________________
Address **[if different from patient]**:_________________________________________________________________
City, State, Zip Code **[if different from patient]**:_______________________________________________________
Home# **[if different from patient]**:(______)_________________ Daytime# **[if different from patient]**:(______)______________________

**Bixby Vision Clinic Insurance and Payment Policy**

**We will need a copy of your insurance cards**

*Please present your insurance cards or verification prior to services rendered. Some insurance policies require preauthorization for services and materials and we are not responsible for failure to get authorizations.*

*Patients are responsible for all co-payments, partially covered and noncovered services at this time of visit. All professional services rendered are charged to the patient. Necessary forms will be completed to expedite insurance carrier payment, however, the patient is responsible for all fees regardless of insurance coverage. If insurance denies a claim, the patient will be billed for services and is responsible for balance due.*

*I hereby authorize Vision Clinics Inc. to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any fees incurred and any amount not covered by insurance.*

Signature ______________________________________________________ Date:_________________
or (if under 18)
Authorized Representative Signature ________________________________________________ (for above patient)

Print Name: __________________________________________________________ Date:_________________

**Bixby Vision Clinic Privacy Policy**

*We are required by law to maintain in the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.*
*Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:*

Signature: __________________________________________________________ Date:_________________

Patient Name:____________________________________ DOB:________________ Chart #:________ Date:____________

## Medical History

*We are asking you to fill out this complete medical history and questionnaire because many diseases and conditions can affect your eyes. All of the information on this form is kept strictly confidential. If you are unable to complete form on your own, one of our staff members will assist you.*
*Do you have any problems with the following areas:*

| | | | | | |
|---|---|---|---|---|---|
| **Autoimmune Disorder** | [ ] Y | [ ] N | **Endocrine** | [ ] Y | [ ] N |
| **Allergies/Hay fever** | [ ] Y | [ ] N | Thyroid/Other Glands | [ ] Y | [ ] N |
| **Cancer** | [ ] Y | [ ] N | DiabetesType_____ | [ ] Y | [ ] N |
| **CardioVascular** | [ ] Y | [ ] N | Date of Diagnosis:_________ | | |
| High Blood Pressure | [ ] Y | [ ] N | **Bones/Joints/Muscles** | [ ] Y | [ ] N |
| **Psychiatric** | [ ] Y | [ ] N | Rheumatoid Arthritis | [ ] Y | [ ] N |
| **Ear/Nose/Mouth/Throat** | [ ] Y | [ ] N | **Neurological** | [ ] Y | [ ] N |
| **Gastrointestinal** | [ ] Y | [ ] N | Headaches | [ ] Y | [ ] N |
| **Genitourinary** | [ ] Y | [ ] N | Migraines | [ ] Y | [ ] N |
| **Integumentary** | [ ] Y | [ ] N | Seizures | [ ] Y | [ ] N |
| **Lymphatic/ Hematologic** | [ ] Y | [ ] N | **Respiratory** | [ ] Y | [ ] N |

If yes, please explain:____________________________________________________________

Are you currently taking medications? [ ] Y [ ] N ***(Please include all prescriptions, over-the-counter and herbal medicines)***

If yes, please list:____________________________________________________________

____________________________________________________________

Are you allergic to any medications? [ ] Y [ ] N If yes, please list:______________________________

## Family History

*Please note any family history (parents, grandparents, siblings, children) with the following conditions:*

| Ocular | | | Relation to you | Medical | | | Relation to you |
|---|---|---|---|---|---|---|---|
| Cataracts | [ ] Y | [ ] N | ____________ | Diabetes | [ ] Y | [ ] N | ____________ |
| Glaucoma | [ ] Y | [ ] N | ____________ | Hypertension | [ ] Y | [ ] N | ____________ |
| Macular Deg. | [ ] Y | [ ] N | ____________ | Thyroid Disease | [ ] Y | [ ] N | ____________ |
| Amblyopia (lazy eye) | [ ] Y | [ ] N | ____________ | Other:____________ | | | ____________ |

## Ocular History

Do you wear glasses? [ ] Y [ ] N Age of glasses: ____________

Do you wear contact lenses? [ ] Y [ ] N Age of contact lenses:____________

Type of contact lenses: Soft RGP/Hard Are your contacts comfortable? [ ]Y [ ]N Brand: ____________

How often do you dispose of your contact lenses? [ ] 1 day [ ] 2 weeks [ ] 1 month [ ] 2 months [ ] Other

Other contact lens information you can provide:____________________________________________

Have you been diagnosed with: [ ] Cataracts [ ] Glaucoma [ ] Macular degeneration Date of diagnosis:__________

Have you ever had any eye injuries or surgeries: [ ] Y [ ] N If yes, please explain:______________________

## Social History

*Please answer for all patients 13 years old and over*

| | Yes | No | If yes, type/amount/how long? |
|---|---|---|---|
| Do you use tobacco products? | [ ] | [ ] | ____________________ |
| Do you drink alcohol? | [ ] | [ ] | ____________________ |
| Do you use illegal drugs? | [ ] | [ ] | ____________________ |
| Are you pregnant and/or nursing? | [ ] | [ ] | ____________________ |
| Do you drive? | [ ] | [ ] | If yes, do you have any visual difficulty?____________ |

Are you a carrier of or infected with [ ] HIV [ ]Gonorrhea [ ]Syphilis [ ] Hepatitis [ ] None

## Reason for Today's Visit: Please mark all that apply

| | | | |
|---|---|---|---|
| [ ] Loss of Vision | [ ] Blurred Vision | [ ] Distorted Vision | [ ] Double Vision |
| [ ] Dryness | [ ] Mucous Discharge | [ ] Sandy or gritty feeling | [ ] Foreign Body Sensation |
| [ ] Redness | [ ] Itching | [ ] Burning | [ ] Excess watering/tearing |
| [ ]Glare or light sensitivity | [ ] Eye pain or soreness | [ ] Flashes or floaters in vision | [ ] Other-List Below |

____________________________________________________________

____________________________________________________________

____________________________________________________________