Broad View Eye Center
Patient History Questionnaire

Mrs. Ms. Mr. Dr. ____Date of Birth: ________________ Age: ___________

Address:____City/State/Zip:_____________________________________

HomeNumber:______________________WorkNumber:________________________SS Number: _________________

E-mail Address: ___________________________________ ___ Occupation: ____________________________________

Date of Last Physical: _______________________________Family Doctor: _____________________________________

Date of Last Eye Exam: _______________________Location of Last Eye Exam: _________________________________

Type of Exam You Are Here For: ☐ Contact Lenses ☐ Spectacles ☐ Both

Whom may we thank for referring you to our office? (Name of friend/relative)____

If not referred, how did you hear about our office for you needs?

☐Yellow Pages ☐Insurance List ☐Newspaper Ad ☐Web Site ☐Saw Sign ☐Another Doctor ☐Other

Medical Information

Do *you* have:

Diabetes:	Y	N	High Blood Pressure:	Y	N	Thyroid Disease	Y	N
High Cholesterol:	Y	N	Suffered from a stroke:	Y	N	Breathing Problems:	Y	N
Allergies:	Y	N	Arthritis:	Y	N	Heart Disease:	Y	N

List *any* medications taken (including eye drops) ____

Please list any other health conditions that you have not listed above (including if you are pregnant or nursing):

____

Personal Eye Information

Do you wear glasses?	Y	N	Do you wear contact lenses?	Y	N
Do you ever see double?	Y	N	Do you get frequent headaches?	Y	N
Do you or any family members have glaucoma?	Y	N	Do you or any family members have cataracts?	Y	N
Do you or any family members have macular degeneration?	Y	N	Do you ever see flashes or floaters?	Y	N
Have you ever been told you have amblyopia "lazy eye" ?	Y	N	Have you ever had any eye injuries or surgeries?	Y	N

What is the major purpose of this visit?____

Are there any problems with your current glasses/contact lenses?____

Lifestyle Questions

Do you have an interested in……

☐ High-definition spectacle lenses?
☐ Changing your eye color?
☐ LASIK surgery
☐ Non-glare lenses?
☐ Sleeping in contact lenses?
☐ Thinner, lighter lenses?

Do you experience…..

☐ Dry, irritated eyes
☐ Uncomfortable contact lenses
☐ Glare or halos at night ?
☐ Sensitivity to light
☐ Itchy eyes
☐ Eyestrain while using computer

What are your favorite hobbies/recreational activities? (Check all that apply):

☐ golf ☐ sewing/needlepoint ☐ reading ☐ boating ☐ computers
☐ fishing ☐ gardening ☐ bicycling ☐ cards/bingo ☐ skiing

Contact Wears Only:

What brand of contacts do you wear? ________________________

What solutions do you use?_________________________________

How often do you replace your contact lenses?

☐ daily ☐ weekly ☐ biweekly ☐ monthly ☐ quarterly ☐ yearly

Please Complete Back Side

Insurance Information

Name of ***Vision*** Insurance: ___________________________________
Policy Holder's Name: _______________________________________
Policy Holder's Date of Birth: __________________________________
Policy Holder's ID (or SSN): ____________________________________
Group Number: ____
Relationship to Policy Holder: self spouse child

Name of ***Medical*** Insurance: _________________________________
Policy Holder's Name: _______________________________________
Policy Holder's Date of Birth: _________________________________
Policy Holder's ID (or SSN): ___________________________________
Group Number: ____
Relationship to Policy Holder: self spouse child

Assignment of Insurance Benefits

I request that payment of authorized insurance benefits be made payable on my behalf to Broad View Eye Center for any services rendered. This assignment will remain in effect until revoked by me in writing. In addition, I understand that I am financially responsible for any co-payments or deductibles required by my insurance company as well as any remaining balance *not* paid by my insurance.

Signature of responsible party ____ Date _____________

Broad View Eye Center Insurance Policy

In order to accommodate the needs and requests of our patients, we have enrolled in numerous insurance programs. While we are pleased to be able to provide this service to you, it is extremely difficult for us to track the individual requirements of each plan. If we are not informed of any special requirements in your contract, and the charges are not covered, you will be responsible for those charges. Your vision and medical health insurance is a contract between you and your insurance carrier. We will do our very best to assist you in submitting your insurance claims to your insurance carriers.

We request all patients to complete a credit card preauthorization form. We expect your insurance company to make payment within 45 days. If your insurance company denies a claim then the charges are considered your responsibility. We will send you a statement of any outstanding balance and give you the opportunity to make payment, if the balance remains after 30 days of the insurance denial, your credit card will be charged and you will be sent a receipt.

I authorize Broad View Eye Center to keep my signature on file and charge my credit card the balance of charges not paid by the insurance company after 30 days of notification.

Credit Card Number: ____ Expires: _______________
Card Holders Name:____
Type of Card: Mastercard Visa AmEx Discover

Cardholder's Signature:____ Date: _________________

I decline to put my credit card on file; however, agree to pay any outstanding balance within 30 days of notification by Broad View Eye Center.

Signature of responsible party: ____ Date: _________________

HIPAA Privacy Acknowledgement of Receipt of Notice of Privacy Practices:

I, _______________________________ [Please print full legal name here], have been presented with the Notice of Privacy Policy (the "Policy") of Broad View Eye Center, and have been offered a copy of such policy to keep for my records.

Signature____Date____________________