Broad View Eye Center
Patient History Questionnaire

Mrs. Ms. Mr. Dr. _____Date of Birth: _____ Age: _____

Address:_____City/State/Zip:_____

Home Number:_____ Cell:_____ Check to opt out of text messages reminders: [ ]

E-mail Address: _____ SSN: _____

Occupation: _____ Date of last Physical: _____

Date of Last Eye Exam: _____Location of Last Eye Exam: _____

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

*How did you hear about our office?*_____

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)

_____

Check the box that best describes your tobacco use:

☐ none ☐former smoker ☐ light smoker < 1 pack/day ☐ average smoker 1-2 packs/day ☐heavy smoker > 2 packs/ day

Check the box that best describes your alcohol use:

☐ none ☐ social use only ☐ 1-2 drinks daily ☐ above average use ☐ alcohol dependence

General Physician:

Name: _____ Pharmacy:_____

Physician phone:_____ Pharmacy phone: _____

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?_____

Non-covered Services

At Broad View Eye Center, we pride ourselves in providing our patients with the highest standard of care. Because of this, we now perform the **Optomap Retinal Exam** on all of our patients. This non-invasive procedure allows our doctors to see a much broader, more detailed view of the retina than with conventional methods. The Doctors at Broad View Eye Center strongly believe the **Optomap Retinal Exam** is an essential part of your comprehensive eye exam and prescribe it for all patients once per year. The $35.00 Optomap sceening copay is generally a non-covered service. Additional common procedures that are frequently not covered by insurance plans include: refractions (quantifying your need for glasses), contact lens services, glasses and contact lenses.

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

Insurance Information

Name of ***Vision*** Insurance: _____
Policy Holder's Name: _____
Policy Holder's Date of Birth: _____
Policy Holder's ID: _____
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: _____
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 or services ***not*** covered 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:_____ CVV _____
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_____

When you are done filling out this form, please bring your insurance card to the front desk so that we may scan it.

Thank you!