EYE ON HEALTH

Today's Date _____

Name _____
First Middle Last

Birthdate ____/____/_____ **MALE** or **FEMALE** (circle one)
Month Day Year

Address _____
Street Apt City State Zip Code

Phone # (cell) _____ Phone # (home) _____

Email _____ Social Security # _____

May we contact you? YES NO **Circle One**: Single Married Divorced Widow

Employer _____

Address _____ Phone _____

Guardian/Spouse Name _____ DOB _____

Address if different from above _____

Phone # _____

Emergency Contact Info (other than spouse/not living at same address)

Name _____ Phone _____

Primary Medical/Health Insurance _____
Member/Subscriber ID # _____ Group # _____
Policy Holder Name & DOB _____

Primary Vision Insurance _____ ID# _____
Policy Holder Name & DOB _____

Secondary/Supplemental Insurance _____

What is the primary reason (complaint) for your visit today? _____

Do you currently wear Glasses ☐ Contacts ☐ What brand of contacts? _____

When was your last eye exam? _____

Have you ever had any eye surgeries or injuries? If so please explain_____
_____

➽Do **YOU** have or ever had any of the following ?

Cataracts ☐	Retina issues/diseases ☐	
Macular Degeneration ☐	Iritis/Uveitis ☐	Dry Eye ☐
Glaucoma ☐	Eye Turn ☐	
Cornea issues/diseases ☐	Amblyopia(lazy eye) ☐	Other _____

➽Do you have any **FAMILY** history of ? If so **WHO** (mother,father,grandma,grandpa,sibling)

Glaucoma _____	Macular Degeneration _____
Retina Disease _____	Blindness _____
Diabetes _____	Heart Disease_____
High Blood Pressure _____	High Cholesterol _____

➽*Please tell us about any medical conditions YOU have :*

1. Diabetes ☐ ⇢ How long? _____Last A1C? ___ ⇢ (Insulin ? Yes or No)

High Blood Pressure ☐	Thyroid Disease ☐
High Cholesterol ☐	Kidney Disease ☐
Heart Disease ☐	Seizures ☐
Blood Disorder ☐	Headaches/Migraines ☐
Autoimmune Disease ☐	Cancer ☐
Asthma ☐	HIV/AIDS ☐
Respiratory Disease ☐	Sinus issues ☐
TB ☐	Seasonal Allergies ☐
Hepatitis ☐	Other _____

Please list ALL medications you take for the above conditions or otherwise

_____
_____
_____
_____
_____

Please List any allergies to medications _____

_____

Are you currently pregnant? (circle one) Yes No

Have you ever smoked tobacco? Circle one

Yes Former ☐ or Current ☐

No

Do you use any illegal drugs? Yes No

Do you have any of the following dry eye symptoms?

Sandy/Gritty sensation ☐
Soreness/Irritation ☐
Burning ☐
Watering/tearing ☐
Trouble wearing contacts ☐

Would you be interested in talking about Dry Eye Treatments ? _____

Who is your Primary Care/Family Physician _____
Practice Name _____ Phone # _____

Specialist Name _____
Specialty _____ Phone # _____

Please list any individuals that we are aloud to give health or billing information to on your behalf

_____

_____

Patient's Rights and Responsibilities :

1. Release of information
   I hereby give consent to Brett A Balocca LLC and associates to release any information regarding my care and treatment as may be required by any insurance carrier for any portions of my bill.

2. Responsibilities for payment/patient agreement:
   I understand that the doctors at Brett A Balocca LLC and associates are not responsible for deductibles made by any insurance company, government agency, HMO/PPO plans, etc. I agree to pay any portion of fees charged by Brett A BAlocca LLC and associates for services rendered to me that are not covered by my insurance company.

3. Assignment of benefits:
   I authorize my insurance company to assign benefits to Brett A Balocca LLC and associates

I have read and understand the above

Patient or Legal Representative Signature

HIPAA Privacy

Acknowledgement of Receipt of Privacy Notice, Financial Responsibility & SIgnature on File

By signing this acknowledgement of Receipt of Notice of Privacy Practice and/or the HIPAA Final Rule 2013 summary of key changes.. (the "Notice"): I acknowledge and agree I have received a copy of the Notice of Privacy Practices for review and to keep for my records on the date identified below.

I understand Brett A Balocca LLC may use and disclose necessary personal health information (for example, my name, address, subscriber identification number, eye exam information and/or type of products provided) to another party to permit Brett A Balocca LLC to perform its administrative duties, provide me with eye care services and products, * process my medical and vision benefits claims*, and communicate with me regarding vision care services provided by Brett A Baloca LLC (for example, mailings of eye exam reminders, or information about services products provided by Brett A Balocca LLC)

Patient or Legal Representative SIgnature Date

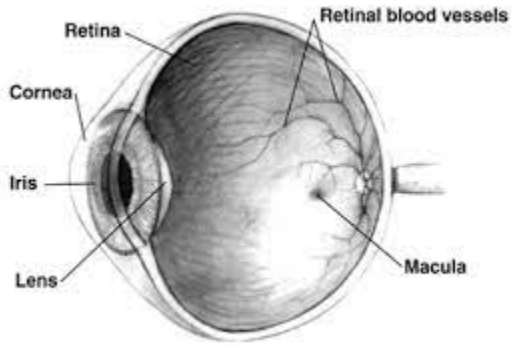
*SIgnature on file

Notice of Health Information Practices

I acknowledge receipt and that I have read and understand the Notice of Health information Practices regarding my provider's participation in The Network, the statewide health information exchange (HIE), or I previously received this information and declined another copy.

Patient or Legal Representative Signature

Retinal Imaging



Our doctor recommends that all patients elect to have their eyes imaged.

Taking the image takes less than half a second and nothing touches your eye at any time. The camera is capable of capturing up to 200 degrees of your eye in one panoramic scan.

Optos scan does not cause blurry vision, light sensitivity or affect driving.

There is a $39.00 co-pay

- [ ] Yes, I would like this procedure performed.

- [ ] I have more questions