EYE ON HEALTH

Date _____

Name _____
First Middle Last

Address _____
Street Apt # City State Zip Code

Home Phone # _____ Work Phone # _____

Cell Phone # _____ Social Security # _____

Date of Birth ____/____/____ Email Address _____
Month Day Year

May We Contact You (Check One) ? ☐ Yes ☐ No

Circle One: Single Married Divorced Widowed

Employeer_____

Address _____ Phone # _____

Guardian / Spouse Information

Name _____
First Middle Last

Address _____
(If different from above) Street Apt # City State Zip Code

Home Phone # _____ Work Phone # _____

Cell Phone # _____

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

Name _____
First Middle Last

Home Phone # _____ Work Phone # _____

How did you hear about us ? _____

In a brief statement, tell us the reason for your visit today. _____

Please list **eye medication(s)** and dosage(s) taken on a regular basis. _____

_____

Please list all **prescription medication(s)** and dosage(s) taken on a regular basis. _____

_____

_____

Primary Care Physician

Name _____ Phone # _____

Specialist

Name _____ Phone # _____

FAMILY HISTORY: In your family history, do any of the following apply? If so, who?

Cataracts _____ Glaucoma _____

Diabetes _____ Other eye disorders/diseases _____

Do <u>you</u> have any of the following problems? (Please check those that pertain to you.)

☐ Diabetes	☐ Heart Problems	☐ Sinus	☐ Seizures
☐ High Blood Pressure	☐ Kidney Problems	☐ Dentures	☐ Shortness of Breath
☐ Chronic Bronchitis	☐ Hearing Impaired	☐ Dizziness	☐ Chest Pain
☐ Tuberculosis	☐ Asthma	☐ Smoker	☐ Hepatitis
☐ High Cholesterol	☐ Bleeding Disorder	☐ Bladder Problems	☐ Other (use line below)

_____

To the best of your knowledge do you have HIV, Aids, or Aids-Related Complex? _____

Allergic to any medications? Yes or No If Yes _____

To the best of your knowledge are you pregnant? ☐ Yes ☐ No

Previous Surgeries in your lifetime (include childhood):_____

☐ Tonsillectomy ☐ Appendectomy ☐ Hysterectomy ☐ Gall Bladder ☐ Prostate

Do <u>you</u> have any of the following ocular problems?

☐ Cataracts	☐ Macular Degeneration	☐ Retinal Detachment	☐ Dry Eye
☐ Glaucoma	☐ Iritis / Uveitis	☐ Retinal Defect	☐ Eye Turn
☐ Corneal Abrasion	☐ Injury	☐ Lazy Eye	☐ Other Eye Disease

INSURANCE INFORMATION:

Primary Insurance _____ Policy # _____ Group # _____

Company Policyholder's Name _____ SS# & DOB _____

Secondary Insurance _____ Policy # _____ Group # _____

Company Policyholder's Name _____ SS# & DOB _____

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. Assignments of benefits:
I authorize my insurance company to assign benefits to Brett A Balocca LLC., and Associates

I have read and understand the above

X _____

Patient or Guarantor Signature Date

HIPPA PRIVACY
Acknowledgement of Receipt of Privacy Notice, Financial Responsibility & Signature on File

By signing this acknowledgement of Receipt of Notice of Privacy Practice (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 my 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 vision and medical benefits claims*, and communicate with me regarding vision care services provided by Brett A Balocca LLC (for example, mailings of eye exam reminders, or information about services or products provided by Bret A Balocca LLC)

X _____

Patient or Patient's Legal Representative Signature Date

*Signature on File

_____

Patient's Name Printed Sponsor (Primary on Insurance) SSN

I hereby acknowledge that I have been presented with a copy of the Brett A Balocca LLC / Eye On Health Notice of Privacy Practices and/or the HIPAA Final Rule 2013 Summary of Key Changes.

Notice of Health Information Practices
I acknowledge receipt and have read and understand the Notice of Health Information Practices regarding my providers participation in The Network, the statewide Health Information Exchange (HIE), or I previously received this information and decline another copy.

X _____

Patient or Legal Representative Signature

Individuals we may give health information to:
Name (Please Print) **Relationship**

_____

_____

_____