

**CONFIDENTIAL PATIENT INFORMATION**

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Sex: M F Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Home Address: \_\_\_\_\_ Apt: # \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ Cell/Alternate: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Email Address : \_\_\_\_\_

If Child, parent's/guardian's name: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Number: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_

Relation: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**Would you like us to communicate to any other family members, Power of Attorney, or other individuals pertaining to your medical records, treatment plan, billing/insurance questions, appointments, etc.? If so, please list below.**

Name : \_\_\_\_\_ Relation to You: \_\_\_\_\_

**Do you allow us to release your medical records to a referring physician or primary care physician if they request such to jointly treat your medical condition? If so, PLEASE INITIAL HERE.** \_\_\_\_\_

**Patient HIPAA Consent:**

In each of our offices, we have our Notice of Privacy Practices published. This Notice contains a Patient Right's Section describing your rights under the law. You have the right to review our Notice before signing this consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have a right to request how protected health information about you is used or disclosed for your treatment, payment, and health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement. Marketing- we may use or disclose your Health Information to make a marketing communication to you that occurs in a face-to-face encounter with us or which concerns a promotional gift of nominal value provided by us.

By signing this form, you consent to our use and disclosure of protected health information about your treatment, payment, and health care operations. You have the right to revoke this consent, in writing, signed by you at any time; however, that does not affect any disclosures we have already made in reliance with your prior consent. This consent is required so that Bowden Eye is in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

**Patient Signature:** \_\_\_\_\_

**Staff Initials:** \_\_\_\_\_

**Relationship if other than patient:** \_\_\_\_\_

List your medication allergies: \_\_\_\_\_

List your current medications you are taking:  
 \_\_\_\_\_

**Please check the box if the current condition applies to you, and explain when necessary.**

- |  |   |
|--|---|
| <input type="checkbox"/> Eye pain              | <input type="checkbox"/> Other Headaches? Explain _____                               |
| <input type="checkbox"/> Red eyes              | <input type="checkbox"/> Difficulty driving due to vision                             |
| <input type="checkbox"/> Watery eyes           | <input type="checkbox"/> Glare from car lights or sunlight                            |
| <input type="checkbox"/> Film over eyes        | <input type="checkbox"/> Double vision  |
| <input type="checkbox"/> Road Signs are blurry | <input type="checkbox"/> Vision blackout  |
| <input type="checkbox"/> Small print is blurry | <input type="checkbox"/> Flashes of light, floaters or spots in vision. Explain _____ |
| <input type="checkbox"/> Dry or scratchy eyes  | <input type="checkbox"/> Do you wear glasses? If yes, are they:                       |
| <input type="checkbox"/> Eye swelling or itch  | <input type="checkbox"/> Prescription and/or <input type="checkbox"/> Reading glasses |
| <input type="checkbox"/> Migraine Headaches    | <input type="checkbox"/> Do you have a known eye disease? If yes, what type? _____    |
| <input type="checkbox"/> Droopy Eyelids        | <input type="checkbox"/> Have you ever had eye surgery? If yes when? _____            |

**Please check the box if you are experiencing any symptoms or have been diagnosed with a condition in these areas:**

- Chronic Fever, unexpected weight gain/loss, fatigue? If yes, when? \_\_\_\_\_
- Ear, nose, throat problems? (e.g. Hearing loss, sinus, sore throat) \_\_\_\_\_
- Heart problems? (e.g. Murmur, CHF, stroke, heart attack, irregular heart beat) \_\_\_\_\_
- High blood pressure? If yes, is it \_\_\_\_\_ controlled or \_\_\_\_\_ uncontrolled?
- Respiratory problems? (e.g. Asthma, emphysema, TB, shortness of breath) If so, when? \_\_\_\_\_
- Urinary problems? (e.g. Pain or discomfort, kidney stones, dialysis, kidney disease) \_\_\_\_\_
- Diabetes or other endocrine problems? \_\_\_\_\_
- Blood or lymphatic disease? (e.g. Free bladder, bleeding disorders, leukemia, etc) \_\_\_\_\_

**Have you ever been told that you have:**

- Gastrointestinal problems? (stomach ulcer, abdominal pain, etc) If yes, when? \_\_\_\_\_
- Allergic or immunologic problems? \_\_\_\_\_
- Cancer? If yes, what type  skin  pituitary  lung  colon  breast  stomach *Other:* \_\_\_\_\_
- Musculoskeletal problems? (e.g. Joint pain, arthritis) If so, when? \_\_\_\_\_
- Skin conditions? Please describe: \_\_\_\_\_
- Neurological problems? (e.g. Numbness, weakness, tingling, headache) \_\_\_\_\_
- Psychological problems? (e.g. depression, anxiety) \_\_\_\_\_

**PAST HISTORY:**

Do you have any other medical conditions or surgery that you have NOT listed in the categories above? \_\_\_\_\_

**CURRENT HISTORY:**

- Have you ever had an HIV (AIDS) test?  YES  NO If so, was it  Positive or  Negative  
 Why was it done? \_\_\_\_\_
- Do you have hepatitis of any form?  YES  NO If so, what type? \_\_\_\_\_
- Have you had any type of blood transfusion since 1980?  YES  NO If yes, why? \_\_\_\_\_
- Have you ever been diagnosed or treated for alcoholism or drug abuse?  YES  NO Please describe. \_\_\_\_\_
- Have you been diagnosed or treated for a mental or emotional condition?  YES  NO Please describe. \_\_\_\_\_

**FAMILY HISTORY: Does/Did anyone in your immediate family have any of the following:**

- |                     |  |   |
|---------------------|--|---|
| Glaucoma            | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Grandparent |
| Blindness           | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Grandparent |
| Diabetes            | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Grandparent |
| Heart Disease       | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Grandparent |
| High Blood Pressure | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Grandparent |

**FOR MEDICATION PRESCRIPTIONS AND REFILLS, PLEASE LET US KNOW WHAT PHARMACY YOU PREFER:**

Pharmacy: \_\_\_\_\_ Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

DOCTOR'S SIGNATURE : \_\_\_\_\_

DATE: \_\_\_\_\_

## MEDICAL EXAM VS. VISION SCREENING EXAM

### What is the difference between a Medical Exam and a Vision Exam?

Insurance coverage for eye exams vary. Some plans only cover routine, well eye exam visits. Other plans will not pay for your exam unless you have a medical eye condition or disease. Some plans require a referral from your primary care physician. Be sure to check your policy(s) to determine your coverage prior to your appointment.

### For insurance purposes, eye examinations are divided into two categories:

**Vision Exam:** These are routine or “Well Vision” exams for patients who have no eye conditions or systemic conditions that affect the vision or ocular health. Your eyes will be examined for any needed vision correction devices such as glasses or contact lenses. If your doctor finds anything abnormal during your well vision exam, further testing of a medical nature will be required at another visit. In rare cases during the technician’s work up we will find medical conditions that require us to convert to a medical examination. Some conditions cannot simply be ignored by a physician solely because of one’s insurance plan. This is best for your ocular health. If we must convert to a medical exam your insurance coverage would be utilized instead of your well care vision plan. **Routine WELL vision exams do not include medication prescriptions of any kind. (New or Refills)** Yearly diabetic eye exams will not be billed to insurances under vision coverage.

**Medical Exam:** This is a comprehensive ocular examinations for the detection, diagnosis, and treatment of diseases and conditions of the eye performed by a physician or surgeon. This exam evaluates the reasons for the systems and assesses any treatment needed. Some conditions evaluated with medical eye exams include cataracts, glaucoma, diabetic retinopathy, macular degeneration and many other potentially sight-threatening diseases. There are many systemic health and family history conditions that can adversely affect the vision.

**Most patients will have a refraction done during both types of exams. A refraction is a diagnostic test used to determine your best corrected vision. For some medical conditions, a refraction is needed even when eyeglasses are not prescribed. The majority of insurance companies do not cover this test. If your insurance does not cover your refraction, you will be asked to pay the fee of \$45 at the time of service.**

Patient’s Initials: \_\_\_\_\_ Date: \_\_\_\_\_

## Lifestyle Questionnaire

This questionnaire is designed to assist your Eyecare Professional in helping you select the perfect lenses, frames, and/or contacts to suit your visual needs and lifestyle. Please take a few minutes to guide us:

**Which of the following visual demands do you encounter on a regular basis? (circle all that apply)**

Artificial Lighting	Computer Work	Potential Eye Hazards	Reading
Board Work	Natural Lighting	Close Up Work	Paperwork

**Which of the following hobbies or activities do you participate in? (circle all that apply)**

Biking	Golf	Sewing/Arts/Crafts	Boating/Water Sports	Home Repairs
Snow sports	Bookkeeping	Hunting/Shooting	Spectator Sports	Tennis
Running	Gardening	Watching TV	Computer Work	Welding
Diving	Pilot	Competitive Sports	Fishing/Boating	Other: _____

**Do your eyes seem bothered by glare from any of the following situations? (circle all that apply)**

Car Headlights	Haze	Traffic Lights	Computer Monitor
Night Driving	Sunshine	Other: _____	

**If you wear contacts, do you have: (circle all that apply)**

Current pair of Prescription Glasses	Sunglasses
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**To be completed by clinical staff.**

Discussion Notes to Optician:

**Frame Preference:** *Metal, plastic, rimless, drill mount*

**Lens Recommendations:** *Single Vision, Progressive, Computer, Polarized Suns*

**Lens Treatments:** *Anti-glare, impact resistant, light weight, thin, blue light, uv protection, polarized, transitions, tint*

**Please let us know which of our specialty services would most benefit your daily life so we may ensure you are fully informed:**

**Vision Correction Services:**

- All Laser Custom LASIK Surgery-** Reduce the need for contacts and glasses
- Custom Premium Cataract Surgery-** Reduce the need for contacts and glasses after the cataract is removed
- Implantable Contact Lenses (ICL)-** Reduce the need for contacts and glasses
- Near Vision CK--** Reduce the need for Reading Glasses
- INTACS-** Treatment for Keratoconus
- Lipiflow-** Dry Eye Relief for itchy, burning, watery eyes
- Allergy Testing-** Proper diagnosis of your allergens that can lead to the correct treatment for your dry, itchy, watery eyes

**Aesthetic Services by Sarah Darbandi, M.D.**

- Coolsculpting--** Non invasive procedure to freeze away unwanted body fat, performed by an MD.
- BOTOX and Fillers-** Reduce the appearance of facial volume loss, fine lines and wrinkles, or even plump your lips
- LATISSE-** Longer, fuller, and darker lashes
- Correction of Droopy Eye Lids or Brows**
- Permanent Make Up Application-** Permanent eyebrows, eyeliner, lip liner, or full lip color
- Photofacial treatment-** Reduce age spots, acne, rosacea, or uneven skin tone
- Lower Eyelid Blepharoplasty-** Improve the look and functionality of your eyelids
- CO2 Laser Resurfacing-** Skin Rejuvenation procedure
- Removal of Lesions around the eyes**

**Hearing Services**

- Complimentary Hearing Evaluation with our Hearing Specialist**