Patient Name: ________________
Account #: ___________________

BOWDEN
EYE & ASSOCIATES
Eyes • Aesthetics • Hearing

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: __________________

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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.

____ Eye pain
____ Red eyes
____ Watery eyes
____ Film over eyes
____ Road Signs are blurry
____ Small print is blurry
____ Dry or scratchy eyes
____ Eye swelling or itch
____ Migraine Headaches
____ Droopy Eyelids
____ Other Headaches? Explain_________________________
____ Difficulty driving due to vision
____ Glare from car lights or sunlight
____ Double vision
____ Vision blackout
____ Flashes of light, floaters or spots in vision. Explain ___________________
____ Do you wear glasses? If yes, are they:
____Prescription and/or _______ Reading glasses
____ Do you have a known eye disease? If yes, what type? ________________
____ 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:

Condition							
Glaucoma	____ YES	____ NO	____ Father	____ Mother	____ Brother	____ Sister	____ Grandparent
Blindness	____ YES	____ NO	____ Father	____ Mother	____ Brother	____ Sister	____ Grandparent
Diabetes	____ YES	____ NO	____ Father	____ Mother	____ Brother	____ Sister	____ Grandparent
Heart Disease	____ YES	____ NO	____ Father	____ Mother	____ Brother	____ Sister	____ Grandparent
High Blood Pressure	____ YES	____ NO	____ Father	____ Mother	____ Brother	____ Sister	____ Grandparent

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

Pharmacy: ______________________ **Address:** ____________________ **Phone Number:** ______________

DOCTOR'S SIGNATURE :________________________________ **DATE:** ____________________

Patient Name: ________________
Account #: ___________________

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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. If your insurance does not cover your refraction, you will be asked to pay the fee of $70 at the time of service.

Patient's Initials: ____________________ Date: __________________

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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

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
___ **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.

___ **BOTOX and Fillers-** Reduce the appearance of facial volume loss, fine lines and wrinkles, or even plump your lips
___ **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**