Bonita Vision Center

Patient ID _____

PATIENT REGISTRATION

Date: _____ Date of Birth: _____ Marital: _____ Sex: ❑ M ❑ F

Race/Ethnicity: ❑ Caucasian ❑ Hispanic ❑ African American ❑ Asian ❑ Native American ❑ Other: _____

Name: _____
(First) (Middle) (Last)

Local Address: _____
(Street / P.O. Box No.) (City) (State) (Zip)

Permanent
Address if different than above: _____
(Street / P.O. Box No.) (City) (State) (Zip)

Local Phone: _____ Work Phone: _____ Northern Phone: _____

Cellular Phone: _____ E:Mail Address: _____

S.S. #: _____ Occupation: _____ Place of Employment: _____

In Case of Emergency Notify: _____ Relationship: _____
(Name) (Phone)

_____ _____
(Primary Medical Insurance) (Vision Insurance) (Policy Holder ID #)

OFFICE POLICY REGARDING PAYMENT

We will file your insurance on your behalf for today's visit. We accept Medicare assignment. Today you are responsible for paying deductibles, copays, as well as fees for non-covered services.

Primary Medical Insurance Holder: _____

DOB: _____ S.S. #: _____ Relationship to Patient: _____

Were you sent to our office by another physician? ❑ Yes ❑ No If yes, who: _____

If other than a physician referral please check the one that best applies to how you heard about us.

❑ Relative/Friend: Name: _____

❑ Magazine ❑ Facebook/Email ❑ Insurance ❑ Website

❑ Other (please be specific): _____

LIFETIME SIGNATURE AUTHORIZATION

In cases where private insurance and or Medicare claims are to be filed, the following form should be completed. In order for us to submit a claim on your behalf for services, we must have your authorization to release medical information.

I hereby authorize Bonita Vision Center to release all medical information and to submit insurance and other claims, including appeals, on my behalf and request payment of Medicare benefits either to myself or to the party who accepts assignment. I understand that I, the patient, am financially responsible for bills submitted and for any balance not paid by insurance. A copy of this signature is valid as the original.

I also give my permission for a report of my evaluation, treatment, and follow up evaluation to be sent to my referring physician and/or family physician.

I have read the above Office Policy and Lifetime Signature Authorization completely. I understand and accept the policy.

Signed: _____ Witness: _____ Date: _____

FOR MINORS:
I give my permission for my minor child, _____, to be treated by Bonita Vision Center.

Signature of Parent or Guardian: _____

MEDICAL HISTORY / REVIEW OF SYSTEMS

NAME: _____ CHART #: _____ DATE: _____

Name/Address/Phone Number of your Primary Doctor: _____

_____

EYE HISTORY / SYMPTOMS:

	Yes	No		Yes	No		Yes	No
Lazy / Cross Eyed	❑	❑	Glaucoma	❑	❑	Eye Pain	❑	❑
Blind Eye	❑	❑	Dry Eyes	❑	❑	Glare & Halos	❑	❑
Cataracts	❑	❑	Baggy Eyelids	❑	❑	Flashes of Light	❑	❑
Double Vision	❑	❑	Eye Disease / Injury	❑	❑	Glare or Trouble Seeing	❑	❑
Floaters	❑	❑	Itchy Eyes	❑	❑	at Night as You've Aged		
Other, Please Explain _____			Retinal Disease	❑	❑			

_____

DO YOU HAVE A FAMILY HISTORY OF:

	Yes	No		Yes	No		Yes	No
Diabetes	❑	❑	Glaucoma	❑	❑	Retinal Disease	❑	❑
Macular Degeneration	❑	❑	Heart Disease	❑	❑	Arthritis	❑	❑
Cancer	❑	❑	High Blood Pressure	❑	❑			

Do You Wear Contacts?: ❑ Yes ❑ No Type: ❑ Soft ❑ Hard

DO YOU HAVE ANY <u>ALLERGIES</u> TO MEDICATIONS ❑ **Yes** ❑ **No**
Please List All: _____

HAVE YOU EVER HAD EYE SURGERY? ❑ Yes ❑ No Type of Surgery? _____
Which Eye? Right Eye Date: _____
Left Eye Date: _____

PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS TO THE BEST OF YOUR ABILITY:

Date of Last Eye Exam: _____ Doctor's Name: _____
Are You Using Eye Drops? ❑ Yes ❑ No Name of Drop: _____
How Many Times a Day? _____

PAST SURGERY HISTORY (within the past 10 years)? Type of Surgery? _____

_____

_____

HAVE YOU EVER HAD OR BEEN TREATED FOR:

	Yes	No		Yes	No		Yes	No
Anxiety / Depression	❑	❑	Headaches	❑	❑	Neurological Condition	❑	❑
Arthritis	❑	❑	Head Injury	❑	❑	Shortness of Breath	❑	❑
Asthma	❑	❑	Hearing Loss	❑	❑	Sinus Problems	❑	❑
Cancer	❑	❑	Heart Condition	❑	❑	Stroke / Seizures	❑	❑
Coronary Artery Disease	❑	❑	Hepatitis	❑	❑	Skin Cancer	❑	❑
Diabetes	❑	❑	High Blood Pressure	❑	❑	Thyroid Condition	❑	❑
Gastro / Intestinal Condition	❑	❑	High Cholesterol	❑	❑			

SOCIAL HISTORY: Do you currently smoke? ❑ Yes ❑ No Have you ever smoked? ❑ Yes ❑ No
Do you consume alcohol? ❑ Yes ❑ No ❑ Daily ❑ Socially ❑ Rarely

IF YOU ANSWERED YES TO ANY OF THE ABOVE, PLEASE EXPLAIN. PLEASE DESCRIBE ANY MEDICAL CONDITION OR SURGERY YOU MAY HAVE/HAD THAT IS NOT LISTED ABOVE. _____

_____

_____

_____

_____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING: _____

Name/Dose/How Often	DATE	DATE	DATE	DATE	DATE	DATE	DATE	DATE	DATE	DATE

Pharmacy: _____ Location: _____ Phone #: _____

PATIENT SIGNATURE: _____ DATE: _____

(OFFICE USE ONLY)

Date/Initial: _____ No Change: _____ Updated/List Attached: _____
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Bonita Vision Center

HIPAA Acknowledgment

I acknowledge that I have been given an opportunity to review the Notice of Privacy Practices of Bonita Vision Center.

Patient Signature	Date	Acct

Payment of Non-Covered Services

The **REFRACTION** is a **non-covered service** for insurance companies. The refraction is a diagnostic test used to determine the amount of corrective lens power required to obtain your best vision. Results of this test are utilized for eye glass prescriptions or to provide measurements for the lens power inserted during cataract surgery. The information provided by the refraction helps the doctor to make accurate medical decisions for your vision care. The **refraction fee is $55.** Without the refraction, we are unable to provide you with a prescription for glasses.

I acknowledge that I have been informed of the following:

1. Known non-covered services are due and payable at the time of service.
2. It is my responsibility to advise the technician or doctor if I do not want a non-covered service before it is provided.
3. Insurance may not pay for all services in full. I may have a co-pay amount or a co-insurance amount due at the time of service or after insurance processes my claim, and I will be responsible for payment.
4. I must provide a correct copy of my insurance card at the time of service. If I fail to do so and timely filing limit passes, I will be responsible for all charges for services rendered.
5. I must provide the office with information regarding any specific vision insurance prior to being seen by the doctor so that an authorization can be obtained. I understand that an authorization to utilize vision insurance is required from the vision insurance company and cannot be obtained after being seen. I understand that a medical diagnosis requires submission of my claim to my medical insurance rather than to my vision insurance.

The **CONTACT LENS EVALUATION** or **RE-EVALUATION** is a **non-covered service** for insurance companies. Any patient requesting contact lens for the first time from us must have an evaluation. The fee includes taking the proper measurements of your eye to determine what lens fits you best, and follow up visits for contact lens checks during the fitting process for **60 days** for a non-medically necessary lens. Specialty lens or medically necessary lens such as those lens for Keratoconus, multifocal, gas permeable or scleral lens, or lens needed for corneal issues will have a longer fitting process that will be determined by the doctor. In all cases, the manufacturer only provides a 60-day warranty on the lens. **Lens, regardless of type, cannot be returned after 60 days from the order date for any reason.** Contact lens cannot be trialed, ordered or dispensed without a contact lens evaluation. **All lens types require an evaluation. Contact lens fitting trial period must be completed within 45 days or additional charges may apply.**

New Lens Wearer or Change in Lens Type $85 - $200 Medically Necessary Fee/Keratoconus $345 and up
Re-Evaluation Fees $45 - $100

PLEASE PRINT PATIENT NAME HERE: _____