Bell Eyecare

Welcome to our office!

Patient Information

NAME_____ _____
Preferred name(optional)

ADDRESS_____
Street City/State/Zip Code

BIRTHDATE_____EMAIL ADDRESS_____

DAYTIME PHONE_____EVENING PHONE_____
Home/Work/Cell Home/Work/Cell

Preferred method of contact: (circle one) __Email __Home Phone __Cell Phone __Work Phone

Other family members who come here:_____

Whom may we thank for this referral?_____

Billing Information

If you have vision insurance, who is the cardholder?_____Birthdate_____

If you do not have insurance, who is the responsible party?_____Birthdate_____

Vision Information

When was your last eye examination?_____Doctor_____

Have you ever worn glasses? _____yes ____no

Do you wear glasses now? _____yes ____no

Do you currently wear contacts? _____yes ____no

Are you interested in contacts today? _____yes ____no

(Patients will be charged a fitting/assessment fee for contact lenses)

Medical Information

Date of last general health exam:_____Doctor_____

Check any of the following health problems you have had.

___Allergies	___High Cholesterol	___Glaucoma
___Asthma	___High Blood Pressure	___Cataracts
___Diabetes	___Skin Conditions	___Macular Degeneration
___Fainting	___Surgical Operations	___Eye Injury
___Headaches	___Thyroid Condition	___Eye Surgery (Including LASIK)

Family History (include parents, grandparents, siblings, children)

___High Blood Pressure ___Diabetes ___Glaucoma ___Cataracts ___Macular Degeneration

What medications are you currently taking?_____

Are you allergic to any medications?_____

_____I acknowledge that I have been offered a copy of Bell Eyecare's Notice of Privacy Practices.

_____I certify that the above information is correct. I also understand that, although I may have insurance, I am responsible for any non-covered services, co-payments, or any claims submitted to my insurance company that are not paid by my insurance company for any reason.

Signature_____Date_____