

Bell Eyecare

Welcome to our office!

Patient Information

NAME _____ Preferred name(optional) _____

ADDRESS _____
Street City/State/Zip Code

BIRTHDATE _____ EMAIL ADDRESS _____

HOME PHONE _____ CELL PHONE _____

Preferred method of contact: (circle one) Email Home Phone Cell Phone

How did you hear about us? _____

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 currently wear contacts? Yes No

Do you wear glasses now? 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.

<input type="checkbox"/> Allergies	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Asthma	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Cataracts
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Skin Conditions	<input type="checkbox"/> Macular Degeneration
<input type="checkbox"/> Fainting	<input type="checkbox"/> Surgical Operations	<input type="checkbox"/> Eye Injury
<input type="checkbox"/> Headaches	<input type="checkbox"/> Thyroid Condition	<input type="checkbox"/> 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? _____

Please **initial** the following:

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

_____ I am aware that my glasses and contact prescriptions are available on my online patient portal at www.Belleyecare.net and I can request Bell Eyecare to print them for me.

_____ 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 _____