

# Great Lakes Eyecare

James Bozic, O.D.

Welcome to our office. Please take a moment to fill out the following information. Thank you.

(Mr)(Mrs)(Ms)(Dr) First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ E-mail Address \_\_\_\_\_

Date of Birth \_\_\_\_\_ Preferred Method to Contact (Home Ph) (Cell Ph) (E-mail) (Text)

Emergency Contact Name \_\_\_\_\_ Relationship \_\_\_\_\_

Emergency Contact Number \_\_\_\_\_ Last Eye Exam Date \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Referred by: (Another Patient) (Healthcare Practitioner) (Insurance) (Internet/Website) (Yellow Pages)

Whom may we thank for referring you to our office? \_\_\_\_\_

## **Medical Information**

Do you have conditions involving any of these body systems? (Please circle Yes or No)

Allergic/Immunologic	Yes/No	Eyes	Yes/No	Mental/Anxiety	Yes/No
Blood/Lymph	Yes/No	Gastrointestinal	Yes/No	Muscles/Bones	Yes/No
Cardiovascular	Yes/No	Headaches	Yes/No	Nervous	Yes/No
Ears/Nose/Throat	Yes/No	High Blood Pressure	Yes/No	Respiratory	Yes/No
Endocrine (glands)	Yes/No	Integumentary (skin)	Yes/No	Urinary	Yes/No

Please explain \_\_\_\_\_

Are you diabetic? Yes/No Type \_\_\_\_\_ Date of Diagnosis \_\_\_\_\_

Current Medications \_\_\_\_\_

Allergies to Medication? Yes/No List \_\_\_\_\_

Family Physician \_\_\_\_\_ Date of Last Visit \_\_\_\_\_

## **Family History**

Diabetes	Yes/No	Relation _____	Glaucoma	Yes/No	Relation _____
High Blood Pres.	Yes/No	Relation _____	Macular Degeneration	Yes/No	Relation _____
Cataracts	Yes/No	Relation _____	Retinal Detachment	Yes/No	Relation _____

## **Personal Eye Information**

Do you have any eye conditions or problems? Yes/No What kind? \_\_\_\_\_

Have you had any eye operations? Yes/No Type \_\_\_\_\_ Date \_\_\_\_\_

Have you had a significant eye injury? Yes/No Kind \_\_\_\_\_ Date \_\_\_\_\_

Do you have: Blurred vision (Yes/No) Cataracts (Yes/No) Dry Eyes (Yes/No)  
Macular Degeneration (Yes/No) Glaucoma (Yes/No) A Lazy Eye (Yes/No)  
Retinal Detachment (Yes/No)

Do you wear glasses? Yes/No Contact Lenses? Yes/No Type: (Rigid) (Soft) (Disposable)

Do you have any hobbies or interests that require specific visual requirements? \_\_\_\_\_

## **Doctor Use Only**

Reviewed by \_\_\_\_\_ Date \_\_\_\_\_

Reviewed by \_\_\_\_\_ Date \_\_\_\_\_

Reviewed by \_\_\_\_\_ Date \_\_\_\_\_

**Insurance Information**

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Name of <i>Vision</i> Insurance: _____	Name of <i>Medical</i> Insurance: _____
Policy Holder's Name: _____	Policy Holder's Name: _____
Policy Holder's Birth Date: _____	Policy Holder's Birth Date: _____
Policy Holder's ID or SSN: _____	Policy Holder's ID or SSN: _____
Group Number: _____	Group Number: _____
Relation to Policy Holder: (Self) (Spouse) (Child)	Relation to Policy Holder: (Self) (Spouse) (Child)

**Assignment of Benefits**

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In order to accommodate the needs and requests of our patients, we are a direct provider for several insurance programs. While we are pleased to be able to provide this service to you, it is extremely difficult for us to track the individual requirements of each plan. On occasion, some medically necessary procedures and materials may not be covered by insurance. ***Patients are responsible for all charges not paid by insurance***, including co-payments and deductibles. Payment for professional services is due at the time of the examination, and balances on materials must be ***paid in full*** before glasses and/or contact lenses can be ordered. ***Professional fees are non-refundable***. We will do our very best to assist you in submitting your insurance claims to your insurance carriers.

I authorize payment of benefits on my behalf to Great Lakes Eyecare and assume responsibility for all charges.

Signature of Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_

**HIPAA Acknowledgement of Receipt of Notice of Privacy Practices**

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I, \_\_\_\_\_ (print full name here), have been presented with the Notice of Privacy Policy of Great Lakes Eyecare, and have been offered a copy of such policy to keep for my records.