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 of Contact (Home Phone) (Cell Phone) (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)

Pupil Dilation

The doctor may want to dilate some patients' pupils to obtain a thorough view of the internal eye. The drops used to do this may cause light sensitivity and blurred close-up vision for a few hours after installation. However, it should not significantly affect distance vision as long as the patient is wearing his or her prescription.

May we dilate your pupils during your exam today? (Yes) (No)

Insurance Information

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

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

Assignment of Benefits

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.

Contact Lens Patients:
To receive a contact lens prescription in addition to that for glasses, a patient is required to pay a contact lens evaluation fee. This fee may not be covered by all vision insurance plans. This fee covers the additional testing and measurements necessary to be fitted successfully with contact lenses, as well as any contact lens-related follow-up visits scheduled within 90 days of the evaluation. Contact lens-related follow-up appointments beyond this 90-day period are subject to office visit charges and/or additional contact lens evaluation charges.

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

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.

Doctor Use Only

Reviewed by:_____	Date:_____	Reviewed by:_____	Date:_____
Reviewed by:_____	Date:_____	Reviewed by:_____	Date:_____
Reviewed by:_____	Date:_____	Reviewed by:_____	Date:_____
Reviewed by:_____	Date:_____	Reviewed by:_____	Date:_____
Reviewed by:_____	Date:_____	Reviewed by:_____	Date:_____