

# 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)

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

**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: _____ |