BRIDGEPORT EYE CENTER

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Miss ____

Last Name First Name MI Suffix Nickname

Address:______________________________________City:________________ State:____ZIP:________

Phone: (___) ___-______ Alternate Phone: (___) ___-______ Email:______________________________

Gender: ☐ M ☐ F Race:____________ Ethnicity:____________ Preferred Language: ________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Date of Birth:___/___/_____ SS# ____/___/______

Employment Status: ☐ Employed ☐ Student ☐ Retired ☐ Other Occupation: ____________________

Employer:______________________________________ Employer Phone: ______________________

Emergency Contact: ______________________________ Emergency Phone: ______________________

Insurance Information

Our office files some types of insurance. If you will be attempting to use insurance for your visit today you must present your insurance card to the receptionist **PRIOR** to being seen by the doctor. Some types of insurance we do not file directly but we will help you file so that you may be reimbursed by your carrier for expenses in our office.

It is the responsibility of the patient to be certain that you are covered for services and that you inform the staff of your benefits when completing this form. The staff will verify your benefits with your carrier. If your appointment is delayed due to benefit verification, the appointment may be rescheduled. All co-pays are due on the date of service. No minor may be examined without a parent in the examination room.

We do not verify benefits after an appointment has been completed. No exceptions. In other words, if you do not have proof of coverage and benefits verified you may NOT present this information at a later date and have a claim filed on your behalf. It is the patient's responsibility to know who their insurance carrier is.

INSURED's Name: ______________________________________INSURED's DOB:________________

INSURED's Relationship to Patient:__________________________ INSURED's Gender: ☐ Male ☐ Female

INSURED's Address:____

INSURED's Phone:__________________________ INSURED's SS#______________________________

HIPPA COMPLIANCY FORM

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

The privacy practices of Bridgeport Eye Center are contained in the **Notice of Privacy Practices.** A viewable copy of this document is available at the front desk. If you wish to obtain a copy of the privacy practices please inform a staff member and copy will be provided to you at no cost. Your signature below indicates you were able to review the Bridgeport Eye Center's **Notice of Privacy Practices**, which explains how your medical information will be used and disclosed.

____
Patient's Printed Name

____
Patient's Date of Birth

____
Signature of Patient or Legal Representative

____
Date

If Legal Representative, Relationship to Patient:______________________________________

Reason for your visit today:____

Your Eye Health History

Any injuries to your eyes?____

Any eye surgeries?____

Any eye medications? (drops, ointment, etc.)__________________________________

Do you have any trouble seeing at night? ☐Yes ☐No

Last Eye exam?______________________ Last Eye Doctor?__________________

Primary vision correction: (please check one)

☐Single vision glasses ☐Bifocal glasses ☐Progressive lens glasses ☐Contacts

CONTACT LENS WEARERS: ☐Hard/Rigid Contacts ☐Soft Contacts

If soft contacts: How often do you discard them?______________What solutions do you use?_________________How many hours do you wear them each day?________

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Your FAMILY EYE Health History

Does anyone in your family have one of these eye problems? (Check all that apply)

☐Glaucoma ☐Macular Degeneration ☐Retinal Detachment ☐Cataracts before age 65 ☐Crossed/Lazy Eye ☐Other_________________________

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YOUR MEDICAL HISTORY		YOUR FAMILY'S MEDICAL HISTORY	
Diabetes?	☐Yes ☐No	Diabetes?	☐Yes ☐No
HTN/High Blood Pressure?	☐Yes ☐No	HTN/High Blood Pressure?	☐Yes ☐No
High Cholesterol?	☐Yes ☐No	High Cholesterol?	☐Yes ☐No
Thyroid Disease?	☐Yes ☐No	Thyroid Disease?	☐Yes ☐No
Cardiovascular/Heart?	☐Yes ☐No	Cardiovascular/Heart?	☐Yes ☐No
Cancer?	☐Yes ☐No	Cancer?	☐Yes ☐No
Other?__________________		Other?__________________	

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Medications/Allergies/Other History:

Current Medications:_____________________ Other Medications:_______________

_______________________________________ Vitamins:_______________________

Medication Allergies:_____________________ Herbals/Other:___________________

Who is your Primary Care Doctor?______________ Name of any specialist you see:______

____

Last visit with your PCP?___________Reason for that visit?______________________

Major injuries, surgeries, or hospitalizations?__________________________________

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Are you pregnant or nursing? ☐Yes ☐No

Did you receive a flu shot with the past 12 months? ☐Yes ☐No

Are you current on Tetanus vaccinaction? ☐Yes ☐No

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Social History

Occupation: _______________Hobbies that affect or use vision:_________________

Smoking Status: ☐Yes ☐No Type: ☐Cigarette ☐Cigar ☐Other How Long:__________

Alcohol Status: ☐Yes ☐No Type: ☐Beer ☐Wine ☐Liquor How Long:__________

Illegal Drugs: ☐Yes ☐No Type: ____________________How Long:__________

Exposure to Hepatitis, AIDS, HIV, HPV or any STD: ☐Yes ☐No

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Race: _______________Ethnicity:__________________Preferred Language:__________

Review of Systems:
(check all that apply)

General:	☐Good Health Overall	☐Fatigue	☐Fever		
Ear, Nose & Throat:	☐Cough	☐Dry Mouth	☐Congestion	☐Allergies	
Vascular/Cardiovascular:	☐Heart Disease	☐High Blood Pressure	☐Vascular Disease		
Respiratory:	☐Asthma	☐Bronchitis	☐Emphysema	☐COPD	
Genito-Urinary:	☐Kidney Problems	☐Bladder Problems	☐Prostate Problems		
Muscles, bones & joints:	☐Arthritis	☐Degeneration			
Gastrointestinal:	☐Crohn's Disease	☐IBS	☐Stomach Upset	☐Acid Reflux	
Skin:	☐Eczema	☐Itching	☐Rosacea	☐Acne	
Neurological:	☐Headache	☐Migraine	☐MS	☐Numbness	☐Seizures
Psychiatric:	☐ADHD	☐Anxiety	☐Depression		
Endocrine:	☐Diabetes, childhood	☐Diabetes, adult	☐Thyroid		
Blood/Lymph:	☐High Cholesterol	☐Anemia	☐Bleeding Disorder		
Allergic/Immunologic:	☐Seasonal				

Notes:

All patients who provide their insurance information prior to being seen, or present it in the office at the time of their appointment will have benefits verified. Your carrier will be contacted by telephone by our insurance clerk who will verify your coverage effective date, limitations and benefits for both examinations and materials. This information is provided to us by an employee of your insurance company and we rely on them to provide accurate and up to date information. Our claims are filed in a timely manner and processed electronically. Within the past twelve months we have experienced a significant increase in claims processing that does not match the verbal benefits which were given at the time of verification. Errors in coverage provided to us by your insurance company prior to being seen do not alleviate financial responsibility for services obtained. If your claim processes differently than what we were informed of regarding your benefits, you will receive an additional bill from this office. The patient is ultimately responsible for services obtained at Bridgeport Eye Center and from Dr. Patricia Young.

Patient:______________________________________

Date of Service:________________________________

Insurance Carrier:_______________________________