my PHARMACY & OPTICAL

Patient Name: ______________________ **Date of Birth:** __________ **M F** **Date:** ________

Home Address: ____
Street City State Zip Code

Primary Phone: ( ) ____________ **Email Address:** ____________________

When was your last eye exam? ____________
Is this exam for contacts? ____________
What is your occupation? ____________
Do you smoke? ______ singles/packs per day? ______
Are you pregnant or nursing? ____________

Do you wear glasses? ____________
What brand of contacts do you wear? ____________
Specific visual needs for work/hobbies: ____________
Do you drink? ______ drinks per day? ______

Medical/Visual History

Please complete the entire form. Circle yes or no for any medical or visual issues you may have.

Condition			Medication
Diabetes:	Yes	No	Medication: ____
High Cholesterol:	Yes	No	Medication: ____
Heart Disease:	Yes	No	Medication: ____
High Blood Pressure:	Yes	No	Medication: ____
Kidney Stones:	Yes	No	Medication: ____
Sinus Issues:	Yes	No	Medication: ____
Seizures:	Yes	No	Medication: ____
Depression/Bipolar:	Yes	No	Medication: ____
Age-Related Arthritis:	Yes	No	Medication: ____
Rheumatoid Arthritis:	Yes	No	Medication: ____
Thyroid Disorder:	Yes	No	Medication: ____
Lupus:	Yes	No	Medication: ____
Crohn's Disease:	Yes	No	Medication: ____
Kidney/Bladder:	Yes	No	Medication: ____
Asthma:	Yes	No	Medication: ____
Sleep Apnea:	Yes	No	Medication: ____
Anxiety Disorder:	Yes	No	Medication: ____
Anemia:	Yes	No	Medication: ____
Herpes Simplex:	Yes	No	Medication: ____
Hepatitis:	Yes	No	Medication: ____
Rosacea:	Yes	No	Medication: ____
COPD:	Yes	No	Medication: ____
ADD:	Yes	No	Medication: ____
Autism:	Yes	No	Medication: ____
Sarcoidosis:	Yes	No	Medication: ____
Sickle Cell:	Yes	No	Medication: ____
HIV Positive:	Yes	No	Medication: ____
Weight Gain/Loss:	Yes	No	Medication: ____
Headache:	Yes	No	Medication: ____
Migraine:	Yes	No	Medication: ____
Osteoporosis:	Yes	No	Medication: ____
Cancer: ____			Medication: ____

Visual History

You or your *immediate* Family

Macular Degeneration ____
Glaucoma ____
Diabetic Retinopathy ____
Lazy Eye ____
Flashes/Floaters ____
Double Vision ____
Crossed/Turned Eye ____
Retinal Detachment ____
Other ____

Have you had cataract surgery?
____

Have you had eye surgeries?
____

Do you have any drug allergies?
____
____

Any other medical problem(s) you would like to include?
____
____
____
____

What is the reason for your visit today? ______________________
____
____
____

Insurance Types

Medical Insurance Name: ______________________ ID# ______________________

Vision Insurance Name: ______________________ ID# ______________________

Primary Insurance Party: Name ______________________ Date of Birth: ______________________

If you wish for anyone to obtain any of your financial and/or health information, please provide us with the names of those individuals:

______________________________ ______________________

Name Relation to Patient

______________________________ ______________________

Name Relation to Patient

Authorization: I authorize any holder of medical or other information about me to release any information needed for this claim to the Social Security Administration and Health Care Financial Administration, its intermediaries or carriers, the billing agent of the supplier, Medicaid, an Insurance Company, or third party payor. I understand that I am responsible for amounts, deductibles, and charges not reimbursed by Medicare, Medicaid, my insurance company, or a third party payor. I permit a copy of this authorization to be used in place of the original signature and request payment of medical insurance benefits be paid to Bergelt Optometric, LLC.

Advance Beneficiary Notice: I further understand that Medicaid does not pay for Vision Therapy (code 92065); Medicare does not pay for a Refraction (code 92015); and Medicaid, Medicare, and Tricare do not pay for contact lens fittings (code 92310).

HIPPA (Health Insurance Portability Accountability Act) Privacy Notice: I have been offered a copy of the office's privacy notice or have read a copy that is on display.

Insurance must be presented at time of service.

Patient/Responsible Party's Signtaure: ______________________

My Optical can send you an electronic copy of your prescription upon request. This is an unencrypted email which will require your consent and authorization to send. By signing and dating below, you authorize My Optical to send you an unencrypted electronic copy of your prescription to your personal email address.

______________________________ ______________________

Patient Signature Date

How did your hear about us?	Social Media	Google	Billboard	Direct Mail
	Referral	Radio	Other: ____________	