Welcome to Broadway Eye Clinic ____Today's Date: _____/_____/_____

First Name:_____Middle I:____Last Name:_____ Nickname:_____

Gender: M F Social Security #: XXX - XX - __ __ __ __

Street Address_____City_____State_____Zip_____

Home Phone_____Daytime Phone_____Cell Phone_____

Email Address_____ Preferred communication: E-mail Mail Phone Text

Birthdate: _____/_____/_____ Age:_____ Height: ____' _____" Weight: _____

Race: Asian American Indian/Alaska Native Black/African American
Hispanic Native Hawiian other pacific Islanders White
Other:_____

Patient Employer (or School)_____ Patient Occupation (or Grade)_____

Spouse _____Phone # _____ Parent (if under 18)_____

Person responsible for account (if not patient)_____Relationship to patient_____

If you are enrolled in a vision plan (VSP, EyeMed, Davis Vision), please list the vision plan as Primary, and the medical as Secondary

We will need a copy of your insurance card and your driver's license/picture id.

Primary Insurance Company_____Insured's Name_____

Insurance ID #_____Insured's Birthdate_____/_____/_____

Secondary Insurance Company_____Insured's Name_____

Insurance ID #_____Insured's Birthdate_____/_____/_____

Name of Medical Doctor: _____ Date of Last Physical Exam: _____/_____/_____

Name of Diabetes Doctor (if applicable, and if different from above):

_____

Personal Review of Systems

CARDIOVASCULAR *(complex part of the body involving the heart and blood vessels)*
None Heart Disease High Cholesterol High Blood Pressure
Other_____

CONSTITUTIONAL *(the makeup or functional habits of the body)*
None Anemia Excessive Hunger/Thirst/Urination Fever
Other_____

EDOCRINE *(endocrine glands and functions to regulate body activities)*
None Diabetes (type___) Gout Hyperthyroid Hypothyroid
Other_____

GASTROINTESTINAL *(the system that makes food absorbable)*
None Constipation Diarrhea Stomach Ulcer
Other_____

GENITOURINARY *(all organs involved in reproduction and in the formation and voidance of urine)*
None Bladder/Kidney Infection Menopause STD
Other_____

HEMATOLOGIC/LYMPHATIC *(blood and blood-producing organs, relating to lymph, lymph vessel, or lymph node)*
None Bleeding Disorder Sickle Cell Disease
Other_____

IMMUNOLOGIC *(immune system, innate and acquired immunity)*
None AIDS/HIV Herpes Zoster (Shingles)
Other_____

INTEGUMENTARY *(skin)*
None Rosacea Skin Cancer
Other_____

MUSCULOSKELETAL *(Muscle and Bones)*
None Arthritis (type_____) Osteoporosis
Other_____

NEUROLOGICAL *(Nervous System)*
None Headaches Multiple Sclerosis Seizures
Other_____

PSYCHIATRIC *(mental and emotional disorders)*
None Anxiety Depression
Other_____

RESPIRATORY *(Lungs)*
None Asthma Chronic Bronchitis Emphysema
Other_____

PERSONAL MEDICAL HISTORY: Injuries, surgeries, and/or infections_____

_____
_____

MEDICATIONS: (including over-the-counter)_____

_____
_____

MEDICATION ALLERGIES: NO YES List of medications allergic to:_____

HAY FEVER ALLERGIES: NO YES Allergic to what:_____

SOCIAL HISTORY: Use of alcohol? NO YES Use of illegal drugs? NO YES

Please Describe/Quantity/Frequency

_____

Use of Tobacco: Never Smoked Former Smoker, Quit: _____ Current Smoker/Amount_____

CURRENT GLASSES STATUS:

Do you currently wear glasses? NO Distance Only Reading Only Computer Full Time

CURRENT CONTACT LENS STATUS:
Do you currently wear contact lenses? NO YES Brand_____Power:
R_____L_____
PERSONAL OCULAR HISTORY: Injuries, surgeries, and/or infections_____
OCULAR MEDICATION: (including over-the-counter)_____
DATE OF LAST EYE EXAM:_____ **EXAMINING DOCTOR:**_____

ARE YOU CURRENTLY PREGNANT? NO YES # of weeks _____ARE YOU CURRENTLY NURSING? NO YES

FAMILY HISTORY SECTION

OCULAR FAMILY HISTORY: (if grandparents please list if they are Maternal or Paternal)

Blindness No Yes Relationship to you_____
Cataracts No Yes Relationship to you _____
Glaucoma No Yes Relationship to you _____
Lazy Eye No Yes Relationship to you _____
Macular Degeneration No Yes Relationship to you _____
Retinal Detachment No Yes Relationship to you _____
Other_____ Relationship to you_____

SYSTEMIC FAMILY HISTORY: (if grandparents please list if they are Maternal or Paternal)

Arthritis (Type_____) No Yes Relationship to you_____
Cancer (Type_____) No Yes Relationship to you_____
Diabetes (Type_____) No Yes Relationship to you_____
Heart Disease No Yes Relationship to you_____
High Cholesterol No Yes Relationship to you_____
High Blood Pressure No Yes Relationship to you_____
Thyroid Disease No Yes Relationship to you_____
Other_____ Relationship to you_____

ADDITIONAL INFORMATION

Reason for your visit today (i.e.: new glasses/contact lenses, LASIK evaluation, dry eye – gritty/sandy/burning/tired feeling – red eye, flashes/floaters, eye pain or discharge, etc.)
_____
_____
Please list any visual needs relating to your occupation, recreation, or hobbies_____
_____
_____

How did you find out about our office? Another Patient? _____Friend? _____ Internet? What site? _____ Another Doctor? _____

Insurance Yellow Pages Employer

BROADWAY EYE CLINIC FINANCIAL POLICY

1. I understand all office charges and co-pays are due at the time of service by cash, check, or credit card. Broadway Eye Clinic will gladly bill my health or vision insurance for services that my insurance authorizes. If the services billed to my insurance are denied, I am responsible to pay upon receipt of the bill in a timely matter.
2. I acknowledge and agree that an interest rate of 1 ½ percent per month (18% annum) will be charged on all balances that remain unpaid 30 days after said date of service. In the event of default and referral to an attorney or collection agency, I agree to pay all collection costs including reasonable attorney fees.
3. I understand Medicare and other health or vision insurances will only pay for services they are obligated under law or under contract to provide. If Medicare or any other insurance denies payment for a reasonable service allowed by law, I understand I am liable for payment for that service.
4. I understand that if I am under Medicare insurance, Medicare does not pay for refraction code 92015. I agree to be personally and fully responsible for payment for that service. I also understand that Medicare does not pay for optical materials (frames, lenses, or contacts) unless immediately after cataract surgery. I agree to pay all material charges, which are allowable, and Medicare does not pay. This includes additional charges for more expensive frames and lenses that I may desire after cataract surgery.
5. I understand that all optical products (glasses and contacts) are custom orders. If I should cancel an order after the manufacturing of the product has started, I will still be liable for the charges.
6. I agree to provide Broadway Eye Clinic with my insurance card so they may copy it for insurance billing information. I understand if I don't provide my insurance card they may be unable to bill my insurance.
7. I consent for Broadway Eye Clinic to use or disclose my health information for treatment, payment and healthcare operations. I understand Broadway Eye Clinic has a Privacy Practices Statement consistent with U.S. law and that I may request a copy of these Privacy Practices.
8. I understand I am entitled to a copy of my contact lens prescription or glasses prescription. I authorize Broadway Eye Clinic to maintain these prescriptions in my medical record and understand that I may request a copy at any time.

PATIENT SIGNATURE:_____DATE:_____

If you are signing as a personal representative of the patient, describe your relationship to the patient and print your name.

RELATIONSHIP TO PATIENT:_____PRINT NAME:_____

Dr. Reviewed _____