



Bartlett, Grigsby, Boan, & Associates, OD, PLLC

Welcome to Our Office!

We want to provide you with the very best in vision care. We realize that your time is valuable and will try to attend to you as quickly as possible. In order for us to serve you better, please provide us with the following information for your records. Of course, all information you provide will be held in strict confidence (please see our "Notice of Privacy Policies" for more details).

Name: (Last) (First) (Middle) Preferred Name: Title: Mr. Mrs. Ms. Miss Dr. Rev. Other: Address: (street) (city, state, zip) Telephone: (home) (work) x Employer: Social Security # E-mail address: (may we send you information via e-mail? Y N) Date of Birth: Sex: M F Referred By: Friend (name: Insurance Drive By Internet Employer Yellow Pages Other:

Approximate Date of Last Eye Exam: Where:

Have you ever worn: Eyeglasses Contact Lenses Do you currently wear: Eyeglasses Contact Lenses

Are you interested in...? (check all that apply): Refractive Surgery (LASIK) No dilation exam (Optos) First time contact lenses 30-day continuous wear contacts Bifocal contact lenses Changing your eye color Removing glare from your glasses

Do you take any medications for your eyes? Y N What:

Do you have (or have you had) any of the following? (check all that apply): Headaches Double Vision Eye Turn Eye surgery Eye Injury Red Eyes Eye itching Burning Eyes Gritty/sandy Feeling in Eyes Eye Pain Floaters Flashing Lights Glare Blurry Vision Distorted Vision Eyelid Problems Other Eye Problems:

Eye History: Have you been diagnosed with any of the following? Eye Turn/Lazy Eye Glaucoma Cataracts Eye Degeneration

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Primary Care Physician: _____ Last Physical (month/year) ___/___

List medications you are currently taking: _____

List medical allergies (if any): _____

Review of Systems (patient only) - Do you have problems with any of the following? (check all that apply):

- | | | | | |
|---|--------------------------|----------------|--------------------------|-----------------|
| <input type="checkbox"/> Nervous System | <input type="checkbox"/> | Bones/Joints | <input type="checkbox"/> | Ear/Nose/Throat |
| <input type="checkbox"/> Blood/Circulation | <input type="checkbox"/> | Genitourinary | <input type="checkbox"/> | Skin |
| <input type="checkbox"/> Respiratory | <input type="checkbox"/> | Cardiovascular | <input type="checkbox"/> | Mental/Psych. |
| <input type="checkbox"/> Endocrine (including diabetes) | | | | |

Has anyone in your immediate family had any of the following? (check all that apply):

- | | | | | |
|---|--------------------------|--------------------|--------------------------|-----------|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> | Hypertension | <input type="checkbox"/> | Thyroid |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> | Glaucoma | <input type="checkbox"/> | Blindness |
| <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> | Other eye disease: | _____ | |

For what medical conditions have you been treated in the last two years?

Do you use tobacco products? No Yes (daily often seldom)

Do you drink alcoholic beverages? No Yes (daily often seldom)

Do you have any substance abuse problems? No Yes

(a)
Pay

Our policy is that payment be rendered at time of service for all professional services. A 50% down payment is required on all ophthalmic materials. Please visit our website at www.ecchickory.com or ask our staff for a copy of our policies regarding returns and refunds.

We will file for assignment on most insurance. If we do not accept assignment on your insurance, you may pay us in full at the time of service and we will file the necessary paperwork (at no charge to you) for your insurance company to reimburse you directly. Even if we agree to file for assignment on your insurance, your bill is still your responsibility. If we do agree to accept assignment, we will make a good faith effort to collect from your insurance company. However, if your insurance company will not pay us (for any reason), the bill is your responsibility. We make every effort to work with our patients on their bills, but delinquent accounts will be settled through the court system or collection agency. Please verify your benefits with your insurance company before coming for your appointment. Any estimate of your charges that we give you based on information your insurance company gives us is not binding if your insurer later reduces payment or denies the claim for any reason.

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our Notice before signing this consent (we can provide you with a paper copy or you can view online at www.ecchickory.com). As provided in the Notice, the terms of the Notice may change. If we change our Notice, you may obtain a revised copy at our website, www.ecchickory.com.

I have read and understand the above Payment Policy. I hereby also acknowledge that I have read and/or received a copy of the Notice of Privacy Practices for Bartlett, Grigsby, Boan, & Associates, OD, PLLC (eyecarecenter).

Patient Name (print): _____

Guardian Name (print) (if patient is under 18 years old): _____

Signature (guardian if patient under 18): _____ Date: ___/___/___