Welcome to Broadway Eye Clinic Today's Date: ____/____/_____

First Name:_____Middle I:____Last Name:_____

Nickname:_____ Gender: M F Social Security #: _____ - ___ - __ __ __ __

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_____

ENDOCRINE *(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:_____
ALLERGIES: NO YES Allergic to what:_____
SOCIAL HISTORY: Use of alcohol? NO YES Use of recreational 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 Insurance Policy

There are two types of health insurance that will help pay for your eye care services. You may have both types and we accept most insurance plans in both categories:

- Vision plans (such as VSP, EyeMed, Davis Vision and others)
- Medical plans (such as Blue Cross/Blue Shield, Medicare and others)

Vision plans only cover routine vision wellness exams and sometimes eyeglasses and contact lenses. Vision plans do not cover medical eye care (the diagnosis and treatment of dry eye, glaucoma, macular degeneration, cataract, etc).

If you have both types of insurance plans it may be necessary for us to bill some services to one plan and some services to the other. We can only bill your vision and/or medical insurance for services if we are a participating provider for that company. In the event that we do not take your major vision or medical insurance, we will provide you with an itemized receipt so you may file for reimbursement with you insurance provider.

Broadway Eye Clinic Financial Policy

1. I understand all charges and co-pays are due at the time of service by cash, check or credit card. Broadway Eye Clinic will bill my vision or health insurance for services that are authorized. If the services billed to my insurance are denied, I am responsible to pay any balance upon receipt of the bill within 90 days.
2. I acknowledge and agree that an interest rate of 1.5% per month (18% annum) will be charged on all balances that remain unpaid 90 days after the 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 to provide under law or contract. If insurance denies payment for reasonable services allowed by law, I understand I am liable for payment of that service.

4. I agree to provide Broadway Eye Clinic with my insurance card so they may copy it for insurance billing information**. I understand if I do not provide an accurate insurance card they may be unable to bill my insurance.**

5. I consent for Broadway Eye Clinic to use or disclose my health information for treatment, payment and healthcare operations. I have had the opportunity to review the Broadway Eye Clinic Privacy Practices consistent with United States law and acknowledge that I have been offered a copy of these Privacy Practices.

6. I understand I am entitled to a copy of my glasses and contact lens 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 representative of the patient, describe your relationship to the patient and print your name.
RELATIONSHIP TO PATIENT/NAME: _____