berri eyecare

WE'RE FOCUSED ON YOUR VISION!

WELCOME TO OUR OFFICE

Today's Date________________

Child's Last________________ First____________ MI____

Birthdate________ Sex____ School______________ Grade_____

Child lives primarily with: Both parents Mother Father Other________

Mother's Last Name________________ First____________

Street________________________________

City________________ State_____ Zip__________

Home Ph____________ Work Ph____________

Cell Ph____________ Email____________

Father's Last Name________________ First____________

Street________________________________

City________________ State_____ Zip__________

Home Ph____________ Work Ph____________

Cell Ph____________ Email____________

Whom may we thank for referring you to our office?____________

Please list other members of your household we have seen.

____

Insurance

Vision Insurance Company________________

Subscriber Name________________

Subscriber SS#____________ Employer____________

Subscriber Birthdate__________ Relationship to Patient__________

Medical Insurance Company________________

Subscriber Name________________

Subscriber SS#____________ Employer____________

Subscriber Birthdate__________ Relationship to Patient__________

Do you participate in a Flex Spending Plan? Yes No

Family Health & Eye History

Please list any **FAMILY MEMBERS** who have the following.

Glaucoma________________

Macular Degeneration________________

Blindness________________

Other Eye Problem________________

Diabetes________________

Heart Disease________________

High Blood Pressure________________

Stroke________________

High Cholesterol________________

Other significant family history________________

Patient Health History

Child's Family Doctor________________

Date of last check-up/physical________________

Medications________________

Allergies________________

Surgeries________________

Any complications during pregnancy or birth?________________

____

Any developmental delays?________________

____

Any school/learning problems?________________

____

Did your child have a fever of 104 or higher before the age of three? Y N

Has **YOUR CHILD** had or been treated for any of the following problems?

___Allergies/Sinus Problems
___High blood Pressure
___High Cholesterol
___Heart Disease
___Diabetes
___Thyroid Disease
___Other Endocrine Disorder
___Acid Reflux
___Irritable Bowel
___Other GI Problem
___Anemia
___Other Blood Disorder
___Immunologic Disorder
___Acne
___Other Skin Disorder
___Rheumatoid Arthritis
___Other Arthritis
___Migraines
___Multiple Sclerosis
___Other Neurological Disorder
___ADD/ADHD
___Depression
___Anxiety
___Other Psychiatric Disorder
___Asthma
___Sleep Apnea
___Other Respiratory Disorder
___Cancer
___Other Problem________________
____

Patient Eye History

Last Eye Exam____________ Where____________

Has **YOUR CHILD** had or been treated for any of the following problems?

___Cataracts
___Corneal Abrasion
___Eye Infection
___Eye Injury
___Glaucoma
___Iritis/Uveitis
___Eye Allergies
___Lazy Eye
___Macular Degeneration
___Retinal Detachment
___Loss of Vision
___Other Vision Disorder

List any eye surgeries________________

Is **YOUR CHILD** experiencing any of the following problems?

___Blurred Vision
___Double Vision
___Frequent Headaches
___Eye Strain
___Eye Pain
___Light Sensitivity
___Flashes of Light
___Spots in Vision
___Poor Night Vision
___Trouble with Glare
___Trouble Reading or Seeing Computer
___Dry or Gritty Eyes
___Watery Eyes
___Itchy Eyes
___Burning Eyes
___Flucuating Vision
___Vision Loss
___Other Vision Problem

Does **YOUR CHILD**... ? (check if answer is YES)

___Wear glasses?
___Use a computer?
___Play sports?
___Have sports glasses?
___Spend a lot of time outdoors?
___Have current back-up glasses?
___Have sunglasses?
___Want to "test-drive" the latest contact lenses?

Financial Responsibility

I agree to pay in full at the time of service, all fees due to Berri Eyecare, including co-pays, co-insurance and fees not covered by insurance. I also understand that should Berri Eyecare file for payment from the patient's insurance company, and those fees are not paid for any reason by the patient's insurance company, I am fully responsible for those fees.

Signature X____________________

Date__________ Relationship to Patient__________

Insurance Authorization

Our Insurance Policy: Berri Eyecare will file insurance claims only with insurance companies with whom we have an active contract. It is your responsibility to know the patient's insurance policy coverage and limits. We may estimate what the insurance company will pay, but the insurance company makes the final determination of payment. You will be responsible in full for any portion not covered or not paid in a timely manner by the patient's insurance company. If you feel the patient's insurance company has wrongly denied the patient's claim, you will need to contact the insurance company. We will be happy to assist if we can.

Authorization

I hereby authorize Berri Eyecare and its doctors to release to the patient's insurance company any information from the patient's examination and/or treatment necessary to process any insurance claim.

I authorize payment of benefits to Berri Eyecare if and when assignment has been accepted.

Signature X____________________

Date__________ Relationship to Patient__________

Privacy Policy Acknowledgement

I acknowledge I have received or have been offered a copy of the "Notice of Privacy Practices" from Berri Eyecare.

Signature X____________________

Date__________ Relationship to Patient__________

Information Sharing

We value your right to privacy. There may be times when it is to your benefit for us to share information with others. This information may include but is not limited to: vision results, test results, prescriptions, contact lens information, diagnosis, treatment, and prognosis.

May we have your permission to share any and all information we have gathered during your eye examination with your **other healthcare providers**?

Please circle one. **YES** **NO**

Sometimes it is helpful if we may discuss your information with a spouse, family member, care giver or other person. Is there anyone (other than one of your healthcare providers) with whom we may share your information?

Please circle one. **YES** **NO**

In the space below, please clearly PRINT the names of anyone we may share any or all information we have gathered during your eye examination.

Name____________________
Relationship to Patient____________________

Name____________________
Relationship to Patient____________________

Name____________________
Relationship to Patient____________________

Name____________________
Relationship to Patient____________________

Name____________________
Relationship to Patient____________________

Name____________________
Relationship to Patient____________________

Signature X____________________

Date__________ Relationship to Patient__________