BAINBRIDGE EYE CARE ASSOCIATES

PATIENT INFORMATION

Mr. Mrs. Ms. Miss Dr. (Circle One) _____ FIRST NAME _____ M.I. _____ LAST NAME _____ PREFERRED NAME

_____ DOB (MM/DD/YYYY) _____ SOCIAL SECURITY NO. **Male Female** (Circle One) _____ OCCUPATION

_____ HOME ADDRESS STREET (INCL. APT #) _____ CITY _____ STATE _____ ZIP CODE

_____ CELL PHONE _____ HOME PHONE _____ WORK PHONE **Cell Home Work** (Circle Preferred Phone)

_____ EMAIL ADDRESS _____ TODAY'S DATE (MM/DD/YYYY)

INSURANCE INFORMATION

_____ VISION INSURANCE COMPANY _____ POLICY/MEMBER ID# **Self Other: fill out below** GUARANTOR (Circle One)

_____ MEDICAL INSURANCE COMPANY _____ POLICY/MEMBER ID# **Self Other: fill out below** GUARANTOR (Circle One)

_____ Secondary INSURANCE COMPANY _____ POLICY/MEMBER ID# **Self Other: fill out below** GUARANTOR (Circle One)

If Guarantor is someone other than the patient, please complete:

Mr. Mrs. Ms. Miss Dr. (Circle One) _____ FIRST NAME _____ M.I. _____ LAST NAME _____ PREFERRED NAME

_____ DOB (MM/DD/YYYY) _____ SOCIAL SECURITY NO. **Male Female** (Circle One) _____ RELATIONSHIP TO PATIENT

_____ HOME ADDRESS STREET (INCL. APT #) _____ CITY _____ STATE _____ ZIP CODE

_____ CELL PHONE _____ HOME PHONE _____ WORK PHONE **Cell Home Work** (Circle Preferred Phone)

_____ EMAIL ADDRESS

REFERRAL INFORMATION

HOW DID YOU FIND OUT ABOUT OUR OFFICE?

- ☐ **Insurance Company**
- ☐ **Drove by/Sign**
- ☐ **I am an existing patient of Dr. Bainbridge**
- ☐ **Internet Search:** _____
- ☐ **Referred by a patient (Name:** _____**)**
- ☐ **Referred by a doctor (Name:** _____**)**
- ☐ **Advertisement (List:** _____**)**
- ☐ **Other:** _____

BAINBRIDGE EYE CARE ASSOCIATES

MEDICAL HISTORY

_____

PATIENT NAME

PAST EYE HISTORY (Give Details Where Appropriate)

Glasses **Y N** _____ Color Deficiency **Y N** _____
Contact Lenses **Y N** _____ Retinal Disorder **Y N** _____
Cataract **Y N** _____ Corneal Disorder **Y N** _____
Glaucoma **Y N** _____ Eyelid Disorder **Y N** _____
Dry Eyes **Y N** _____ Muscle Disorder **Y N** _____
Other **Y N** _____

Surgical or laser procedures of the eye: _____

List any of your activities that require special vision considerations (computer work, cross-stitching, golf, reading, etc.):

_____

PAST MEDICAL HISTORY (Give Details Where Appropriate)

Hearing Difficulty **Y N** _____ Lupus/Sarcoid **Y N** _____
Sinus/Ear/Nose/Throat Problem **Y N** _____ Rosacea **Y N** _____
Diabetes (Type & Duration?) **Y N** _____ Asthma/Lung Disorder **Y N** _____
High Blood Pressure (Duration?) **Y N** _____ Tuberculosis **Y N** _____
Heart Disease **Y N** _____ Skin Disorder/Growth **Y N** _____
Irregular Heart Beat **Y N** _____ Arthritis (Osteo/Rheumatoid?) **Y N** _____
Pacemaker **Y N** _____ Thyroid Disorder **Y N** _____
Rheumatic Fever **Y N** _____ Gastrointestinal Disorder **Y N** _____
Stroke **Y N** _____ Hepatitis **Y N** _____
Carotid Artery Disease **Y N** _____ Herpes/Shingles **Y N** _____
High Cholesterol **Y N** _____ HIV **Y N** _____
Headache/Migrane **Y N** _____ Psychiatric Disorder **Y N** _____
Head Trauma **Y N** _____ Blood Disorder **Y N** _____
Epilepsy/Seizures **Y N** _____ Cancer (Type?) **Y N** _____

Other surgical procedures: _____

FAMILY HEALTH HISTORY (Give Details Where Appropriate)

High Blood Pressure **Y N** _____ Abnormal Eye Turning **Y N** _____
Diabetes **Y N** _____ Macular Degeneration **Y N** _____
Glaucoma **Y N** _____ Blindness (Cause?) **Y N** _____
Retinal Detachment **Y N** _____ Other **Y N** _____

SOCIAL HISTORY

Do you work with fumes, chemicals or a dusty environment? **Y N** Do you drive? **Y N Daylight Hours Only**
Do you use a computer? **Y N** Average daily hours: _____ Do you smoke? **Y N** Packs per day/week: _____
Do you drink alcohol? **Y N** ☐ Daily ☐ 1-2 glasses/week ☐ 1-2 glasses/month Do you use recreation drugs? **Y N**

MEDICATIONS (List all medications): _____

☐ I take no medications ☐ I am providing a separate medication list ☐ More are listed on the back

ALLERGIES (List all known allergies): _____

☐ I have no known allergies

To my knowledge, the information provided here is accurate and complete.

Signature of Patient/Guardian: _____ **Date:** _____

Initials: _____ Updated: _____ | Initials: _____ Updated: _____ | Initials: _____ Updated: _____

For Office Use Only								
Information reviewed/updated:	Date _____	Dr _____	Date _____	Dr _____	Date _____	Dr _____	Date _____	Dr _____
	Date _____	Dr _____	Date _____	Dr _____	Date _____	Dr _____	Date _____	Dr _____

BAINBRIDGE EYE CARE ASSOCIATES

REVIEW OF SYSTEMS

_____

PATIENT NAME

CONSTITUTIONAL
Y N Headache
Y N Lethargy/weakness
Y N Chills/night sweats
Y N Fever
Y N Fainting spells
Y N Unconscious
Y N Weight loss
Y N Dizziness

EYES
Y N Wears glasses
Y N Eyesight worsening
Y N Double vision
Y N Eye pain
Y N History of eye surgery

EARS/NOSE/MOUTH/THROAT
Y N Deafness
Y N Noise in ears
Y N Congestion/sneezing
Y N Nose bleeds
Y N Sore throat or tongue
Y N Hoarse voice
Y N Sinus trouble/hay fever
Y N Dental problems

CARDIOVASCULAR
Y N Chest pain with exertion
Y N Heart attack
Y N Heart murmur
Y N Heart racing/palpitations
Y N Irregular heart beat
Y N Mitral valve prolapse
Y N High blood pressure
Y N Swollen feet/ankles
Y N Heart valve replacement
Y N Atrial fibrillation

RESPIRATORY
Y N Lung cancer
Y N Shortness of breath
Y N Chest Pain
Y N Cough up phlegm/blood
Y N Wheezing/coughing
Y N Pneumonia

GASTROINTESTINAL
Y N Trouble swallowing
Y N Heartburn/indigestion
Y N Change in bowel habits
Y N Loose stool/diarrhea
Y N Frequent stomach pain
Y N Vomiting blood
Y N Constipation
Y N Irritable bowel
Y N Ulcers
Y N Stomach/bowel cancer

MUSCULOSKELETAL
Y N Back pain
Y N Neck pain
Y N Back surgery
Y N Arthritis
Y N Fibromyalgia
Y N Aching muscles/joints
Y N Shoe lift or brace
Y N Bone/joint injury
Y N Osteoporosis

INTEGUMENTARY
Y N Rashes
Y N Birthmarks
Y N Sores
Y N Dry/oily skin
Y N Hair growth/loss
Y N Skin Cancer

BREAST/MENSTRUAL
Y N Endometriosis
Y N Are you pregnant?
Y N Irregular periods
Y N Breast discharge
Y N Lumps in breast
Y N Breast Cancer

GENITOURINARY
Y N Frequent urination
Y N Burning on urination
Y N Pus/blood in urine
Y N Trouble starting urination
Y N Loss of urine control
Y N Prostate disease/cancer
Y N Sexual difficulty

NEUROLOGICAL
Y N Stroke
Y N Seizures
Y N Head injury
Y N Memory loss
Y N Confusion
Y N Trouble speaking
Y N Trouble swallowing
Y N Unsteady gait
Y N Trouble walking
Y N Arm/leg weakness
Y N Arm/leg tingling/numbness

PSYCHIATRIC
Y N Nervous breakdown
Y N Panic attacks
Y N Depression
Y N Worry a lot
Y N Considered suicide
Y N Loss of interest in eating
Y N Anxiety/tension
Y N Loss of energy/fatigue

ENDOCRINE
Y N Unwanted weight change
Y N Change in skin
Y N Excessive thirst
Y N Excessive tiredness

HEMATOLOGIC/LYMPHATIC
Y N Blood disease
Y N Enlarged glands
Y N Bleed/bruise easily
Y N Anemia/low blood

ALLERGIC/IMMUNOLOGIC
Y N Allergic Reaction
Y N Recurrent infections

SLEEP
Y N Sleep walk
Y N Legs twitch
Y N Daytime drowsiness
Y N Snores
Y N Breath holding/gasping
Y N Restless sleep

Signature of Patient/Guardian: _____ **Date:** _____

Initials: _____ Updated: _____ | Initials: _____ Updated: _____ | Initials: _____ Updated: _____

For Office Use Only								
Information reviewed/updated:	Date _____	Dr _____	Date _____	Dr _____	Date _____	Dr _____	Date _____	Dr _____
	Date _____	Dr _____	Date _____	Dr _____	Date _____	Dr _____	Date _____	Dr _____

Digital Retinal Screening

The health of your eyes is the most important component of your eye exam and therefore we at Bainbridge Eye Care are proud to offer the **most advanced technology** available. **Digital Retinal Screening** allows us to take a high-resolution digital photograph of the back interior portion of your eye called the retina.

Digital Retinal Screening assures that both eye and general medical problems are detected at the earliest onset – problems that include glaucoma, macular degeneration, retinal detachments and holes, optic nerve disease, diabetes, high blood pressure, stroke, etc. These can lead to serious health problems, including partial vision loss or blindness. **Unfortunately, they often develop without warning and progress with no symptoms** until significant damage has already been done.

Digital imaging provides a permanent record of changes in your eye, making possible side-by-side comparisons year after year. This allows Dr. Bainbridge to monitor even the slightest progression of any abnormalities.

Medical insurance **will** cover retinal photography when there is ***previously known eye disease*** being documented. Unfortunately routine vision insurance **does not** cover advanced procedures like the Digital Retinal Screening to detect ***yet-undiscovered eye disease***. The cost of the Digital Retinal Screening is ***$35*** in addition to the basic eye exam, a small price to pay for the peace of mind and early detection that it offers.

We are very proud to be able to offer this level of advanced care and invite you to take full advantage of it today.

DATE	INITIALS	SELECTION	
__________	________	❑ Yes, I would like Digital Retinal Screening	❑ No, I decline
__________	________	❑ Yes, I would like Digital Retinal Screening	❑ No, I decline
__________	________	❑ Yes, I would like Digital Retinal Screening	❑ No, I decline
__________	________	❑ Yes, I would like Digital Retinal Screening	❑ No, I decline
__________	________	❑ Yes, I would like Digital Retinal Screening	❑ No, I decline
__________	________	❑ Yes, I would like Digital Retinal Screening	❑ No, I decline
__________	________	❑ Yes, I would like Digital Retinal Screening	❑ No, I decline
__________	________	❑ Yes, I would like Digital Retinal Screening	❑ No, I decline
__________	________	❑ Yes, I would like Digital Retinal Screening	❑ No, I decline
__________	________	❑ Yes, I would like Digital Retinal Screening	❑ No, I decline

TODD T. BAINBRIDGE, O.D.
BAINBRIDGE EYE CARE ASSOCIATES
1255 WEST CHESTER PIKE, WEST CHESTER, PA 19382
PHONE 610-692-2212 FAX 610-692-2235

INSURANCE AUTHORIZATION AND BINDING FINANCIAL AGREEMENT

Providing the best possible eye care involves a mutual understanding between patient and provider. Should you have any questions regarding the following policies, please ask for clarification. Our professional services are rendered to you, not your insurance company. Ultimately, payment for our services is YOUR RESPONSIBILITY.

- I authorize Bainbridge Eye Care to release any information regarding my care to expedite claims and to bill my insurance company for services provided to me and with payment made directly to the provider's office and that such authorization is valid until written notice is provided to cancel that authorization.

- **While Bainbridge Eye Care makes considerable effort to verify my insurance coverage, benefits, and cost-shares, I understand that such information is NOT an official or legally binding estimate of my out-of-pocket expenses. Ultimately, my final cost share is dependent on the decision of my insurance carrier. I UNDERSTAND THAT ANY CO-PAY ESTIMATES GIVEN TO ME PRIOR TO MY EXAMINATION MAY TURN OUT TO BE DIFFERENT FROM THE FINAL DECISION OF MY INSURANCE CARRIER AND I AGREE THAT I AM DIRECTLY AND FULLY RESPONSIBLE TO BAINBRIDGE EYE CARE FOR PAYMENT OF ALL CHARGES, INCLUDING ANY AMOUNT IN EXCESS OF PREVIOUS CO-PAY ESTIMATES. I realize that if my insurance company fails to pay its anticipated balance in full or payment is not made within 45 days it is my responsibility to pay the doctor's bill and that I will pay collection fees, attorney's fees, court costs, etc. for the purpose of collection on delinquent accounts.**

- In the event that I receive payment from my insurance company for services provided in this office, I agree to endorse any received payment to the doctor's office.

- **I understand there may be medical findings during the course of my exam. I understand it is a VIOLATION of Bainbridge Eye Care's provider agreement with my insurance company to bill such medically-related services to my vision wellness plan. In this event, my medical insurance will be billed and I understand I will be responsible for any applicable co-pays, cost-shares, and/or deductibles as per my agreement with my insurance company. I also understand that Bainbridge Eye Care will not neglect nor overlook medical findings in order to bill my vision wellness plan, as that would put Bainbridge Eye Care in direct conflict with its ethical obligations to the Pennsylvania Board of Optometry.**

- I understand there is a $35 fee for all checks returned unpaid.

- I understand and agree to all statements made herein and understand this is a legally binding agreement.

Signature: _____ Date: _____

Witness: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

By signing below you attest that you have received, reviewed, and understood this practice's privacy policy and the rights to privacy that you are afforded by federal legislation (HIPAA Privacy Act). The privacy policy outlines how your information is shared only for the purpose of performing service or collecting payment. These policies are subject to change without further notice, though a copy of the current policy is always available to any patient.

Signature: _____ Date: _____

NOTICE OF CANCELED APPOINTMENTS

At Bainbridge Eye Care, we understand that occasionally our patient's schedules change at the last minute. If, however, we notice a trend of missing appointments, we reserve the right to discontinue scheduling your appointments in advance and instead offer you same day appointments only.

Signature: _____ Date: _____