Welcome to The Family Eye Group

Patient Information:

Date:_____ Name:_____

Date of Birth:_____ SSN:_____ Age:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Contact Information:

Cell:_____ Work:_____

Home:_____ Email:_____

Notice of Privacy

I acknowledge that I have been informed of The Family Eye Group Notice of Privacy.

_____

Patient/Guardian Signature Date

Contact Lens Agreement:

The contact lens evaluation fee includes all follow up visits for **30** days. Contact lens prescription will only be released after the initial evaluation period is successfully completed(which may include examination, fitting,and follow up). After **30** days,(if follow up was requested by Dr. Bonds has not been performed) office visit fees will be applied.

_____

Patient/Guardian Signature Date

Payment Agreement

Our office is doing everything possible to maximize the efficiency and minimize the cost of your healthcare. It is a courtesy to our patients that we file your insurance. In order to accomplish this please have all your insurance cards present. Due to copays, deductibles, or non-covered procedures or products, your insurance may reject some or all of the billed charges. **Copays are due at time of service.** Should it become necessary to bill you for the services rendered a $10.00 billing fee along with a monthly finance charge will be added to your account.

Authorization

I authorize the release of any medical or other information necessary to process this claim. I also authorize payment of my medical benefits to The Family Eye Group/Dr Carrie Bonds for services provided. I understand that in the event my insurance claim is denied, I will be responsible for any remaining balance.

Date:_____

Print Name:_____

Signature:_____

Relationship to patient:_____

If primary card holder is different from patient:

Name:_____

Date of Birth:_____

Medications

Please list all medications, along with the dosage, you are currently taking including over the counter medicine and eye drops:

_____

_____

_____

_____

Allergies

Are you allergic to any drugs or medicines? Yes No

If so, list drug(s): _____

Please circle if you are allergic to the following: Latex, Dust, Animal Dander, Environmental Allergies

Other allergies: _____

Eye Health History

Please circle all that apply to you:

Blurred vision- near
Blurred vision- distance
Burning
Light Sensitivity
Crossed Eyes
Discharge from eyes
Double Vision
Macular Degeneration
Poor Color Vision
Retinal Detachment
Sties / Chalazions
Foreign Body Sensation
Watery eyes
Headaches
Itchy Eyes
Lazy Eye
Cataracts
Loss of Vision
Dry Eyes
Eye Infection
Red Eyes
Eye Pain
Seeing Halos
Floaters
Tired Eyes
Glaucoma

Other: _____

Do you require any special visual requirements (sports/hobbies)? _____

_____

Current Height: _____

Current Weight: _____

Personal Health History

Please circle all that **CURRENTLY** apply to you:

Constitutional:
Developmental
Cancer
Fatigue Syndrome

Ears, Nose, Throat:
Hearing Loss
Sinusitis
Dry Mouth
Laryngitis

Neurological:
Multiple Sclerosis
Epilepsy
Cerebral Palsy
Tumor
Stroke/CVA
Migraine

Mental Health:
Depression
Attention Deficit
Anxiety
Bipolar Disorder

Cardiovascular:
Hypertension
Heart Disease
Vascular Disease
Congestive Heart

Respiratory:
Cigarette Smoker
Asthma
Bronchitis
Emphysema
Chronic Obstruction
Sleep Apnea

Gastrointestinal:
Chron's
Colitis
Ulcer
Acid Reflux
Celiac Disease

Genitourinary:
Kidney Disease
Prostate Problems
Herpes
Chlamydia
Pregnant/Nursing

Allergy/Immune:
Drug Allergies
Environmental Allergies
Rheumatoid Arthritis
Lupus
Sjorgren Syndrome

Integumentary:
Eczema
Rosacea
Psoriasis
Cold Sores
Shingles

Endocrine:
Type 2 Diabetes
Type 1 Diabetes
Thyroid
Hormone Dysfunction

Hematology/Lymphatic:
Anemia
Bleeding
High Cholesterol

Musculoskeletal:
Arthritis
Osteoarthritis
Fibromyalgia
Muscular Dystrophy
Ankylosing Spondylitis
Osteoporosis
Gout

Family Health History

Please circle if any blood relative to you has any of the following:

Glaucoma Blindness Lazy Eye Macular Degeneration Eye Turns Cataracts

Color Blindness Thyroid Lupus Diabetes Heart Disease High Blood Pressure

Lung Disease Stroke Cancer

Do you smoke? _____ Have you ever smoked? _____
Smoking Preferences? Please circle: Cigarettes Cigars Smokeless Tobacco
Do you drink alcohol? _____ If so, how often? _____
Do you use illegal drugs? _____ If so, how often? _____
Have you ever been infected with? Please circle: Gonorrhea Hepatitis HIV Syphilis

Patient/Guardian Signature: _____ Date: _____

AUTHORIZATION FOR THE USE AND DISCLOSURE OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations.

1. Persons/organizations authorized to use or disclose the information:
   Office of Dr. C.E. Bonds, LLC. The Family Eye Group (Practice Name)

2. Persons/organizations authorized to receive the information: Lenscrafters.

3. Specific description of information that may be used/disclosed: My name, address, telephone number, email address and next appointment date(s) and time(s).

4. **As part of our recall program, the information might be used/disclosed for the following purposes:**
   a) For the purpose of providing LensCrafters coupons and service and product information either from this office or directly from LensCrafters; and
   b) To compare contact lists with LensCrafters to help avoid duplicate contacts related to eye exam scheduling within similar time frames.

5. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment, receive payment or eligibility for benefits unless allowed by law.

6. The organization authorized to use/disclose the information will receive compensation for doing so.
   Yes____ No_X_

7. I understand that I may inspect or copy the information used or disclosed.

8. I understand that I may revoke this authorization at any time by notifying the person/organization providing the information in writing, except to the extent that:
   a) action has been taken in reliance on this authorization; or
   b) if this authorization is obtained as a condition for obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy.

9. This authorization expires four years from the date of my signature.

Signature of patient or patient's representative	Date
Printed name of patient or patient's representative	Relationship to patient or representative's authority to act for the patient