



WELCOME TO BARD OPTICAL
PATIENT HISTORY EVALUATION

Appt. Date
Time
Data Entry
Mkt Code

Thank you for choosing Bard Optical. Please take a moment to answer these questions to help us better evaluate your eye care needs.

Mr./Mrs./Ms. Name
Date
Street Address
Hm. Ph.
City, State, Zip
Wk.Ph. ext:
Cell Ph.

Patient Employer Occupation SS#

Sex M F Date of Birth Spouse Employer

E-Mail Address: [grid] Do you wish to receive Text Messages? Y N

What brought you to Bard? [checkboxes]
Check One [checkboxes]

If you were referred, whom may we thank?

Main reason for today's visit

Do you feel a change in your vision? At a distance? When reading? Both?

Do you wear glasses? Constantly? Distance only? Reading only? None?

If you are currently wearing contact lenses, what type are they?

Patient eye color is: [checkboxes]

When was your last complete eye examination (Optometrist or Ophthalmologist)?

List all medications (including birth control) you are currently taking:

Please list all allergies, including medications:

Do you have a personal history of any of the following (check only those that apply):

- [checkboxes] Eye Infections, Flashing Light(s), Stroke, Multiple Sclerosis, Headaches, Floaters, Cancer, Allergies, Poor Night Vision, Cataract(s), Macular Degeneration, Other health problems, Double Vision, Cataract Surgery, Diabetes, Other eye surgery or injuries, Lazy Eye, Glaucoma, High Blood Pressure, Crossed Eye(s), Light Sensitivity, Thyroid problems

Do you have a family history of any of the following (check only those that apply):

- [checkboxes] Cataracts, Blindness, Diabetes, High Blood Pressure, Glaucoma, Crossed Eye(s), Cancer, Macular Degeneration

RACE:

- [checkboxes] Black or African America, American Indian or Alaska Native, Hispanic, Asian, White, Native Hawaiian/Other Pacific Islander

PREFERRED LANGUAGE:

- [checkboxes] English, Spanish

ETHNICITY:

- [checkboxes] Hispanic or Latino, Native Hawaiian/Other Pacific Islander, Not Hispanic or Latino

COMMUNICATION PREFERENCE:

- [checkboxes] Email, Postal Mail, Telephone

Is your visit covered by any type of insurance? Yes No If yes, with whom? _____

Insured: _____ Date of Birth _____ SS# _____

Is there a second insurance involved? _____ Yes No If yes, with whom? _____

Do you have MEDICARE PART B insurance? Yes No If yes, please leave your insurance card with the front desk personnel.

Patient Signature: _____

If Patient is a minor, signature of Parent or Legal Guardian: _____

Address of Parent or Guardian, if different: _____

If the Patient is a Minor:

Father: _____ SS# _____ Employer _____

Mother: _____ SS# _____ Employer _____

If you answered "yes" to any of the above insurance questions, please present insurance cards to optician and complete insurance agreement below.

Payment is required at time of service.

Please check your method of payment: Cash Check Credit Card Debit Card Gift Card Gift Certificate

INSURANCE AGREEMENT

I understand Bard Optical processes insurance claims as an additional service for its patients. I hereby authorize my insurer to pay Bard Optical any benefits due me under my insurance services rendered by Bard Optical. I also authorize disclosure of my records to any party involved for my treatment.

Bard Optical will make every attempt possible to verify my benefits; however, the contractual relationship is between my carrier and me. Bard Optical cannot be responsible for the accuracy of the information gathered and authorization obtained at the time of service does not guarantee payment. If my insurance claim is denied or payment is not as submitted, I will remain responsible for the amount due or any portion thereof.

I also agree to be responsible for any reasonable fees necessary for the collection of my obligation to Bard Optical, including reasonable attorney's fees.

Signature

Date