BEALS OPTOMETRY

Welcome to Beals Optometry

Where the difference is Clear. The difference is Care.

Name _____ Date of Birth _____

Nickname: (Please call me) _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ ☐ (check preferred contact number)

Cell Phone _____ ☐ Ok to text? _____

Work Phone _____ ☐

E-mail _____

If Child: Parents(s) _____

Do you use a computer? _____ Hours per day _____

Primary physician _____

Clinic _____

Who may we share information with? _____

Relationship _____

Please present all insurance information at the time of your exam.

Signature for release to Insurance:

I authorize the release of any information including the diagnosis and records of any treatment or examination rendered to me or my child during the period of care to third-party payers and or health practitioners. I authorize and request my insurance company to pay directly to the doctor, insurance benefits otherwise payable to me. I understand that insurance is a contract between myself and the Insurer and Beals Optometry cannot guarantee payment from your insurer. I also understand that my insurance carrier may pay less than the actual bill for services and or materials. I agree to be responsible for payment of all services and materials rendered for myself or my dependent.

Signature of Patient (or Parent if Minor) _____ Date _____

Signature for HIPPA:

Our notice of privacy practices ensures the confidentiality of your private information. A copy of the HIPPA notice is available for your review. I wish to continue my care with Beals Optometry under the terms.

Signature of Patient (or Parent if Minor) _____ Date _____

BEALS OPTOMETRY New Patient History Form

Name: _____ Date of Birth: _____ Today's Date: _____

Reason for today's visit: _____

When was your last visit to an eye doctor? _____

What are your visual symptoms? (circle all that apply)

Blurry Vision-Distance	Burning Eyes	Floaters or Spots	Headaches
Blurry Vision-Near	Itchy Eyes	Seeing Flashes	Migraine Headaches
Double Vision	Dry Eyes	Poor Night Vision	Crossed/Turned Eyes
Eye Strain	Red Eye(s)	Light Sensitivity	Eye Infection
Watery Eyes	Sandy/Gritty Feeling	Droopy Lid	Eye Pain

Do you wear glasses? Yes No All the time / Sometimes / Work Only/ Reading Only / Driving only

Do you wear contact lenses? Yes No Type: _____

Do you smoke? Yes No Are you pregnant? Yes No Not Applicable

List current MEDICATIONS (or provide list): _____

List ALLERGIES: _____

DISEASE HISTORY: SELF or FAMILY

Please check the box if you have the disease or condition.

DISEASE/CONDITION	If relative, please explain who:
☐ Glaucoma	_____
☐ Cataracts	_____
☐ Macular Degeneration	_____
☐ Retinal Detachment	_____
☐ Crossed or Lazy Eye	_____
☐ Other Eye Disease	_____
☐ Diabetes A1c: _____	_____
☐ Heart Disease	_____
☐ High Blood Pressure	_____
☐ Multiple Sclerosis	_____
☐ Arthritis	_____
☐ Asthma	_____
☐ Lupus	_____
☐ Anxiety/Psychological Condition	_____
☐ Cancer	_____
☐ OTHER _____	_____

FOR OFFICE USE ONLY:

Review Date: _____ Review Date: _____ Review Date: _____ Review Date: _____ Review Date: _____

Provider: _____ Provider: _____ Provider: _____ Provider: _____ Provider: _____