Welcome to . Thank you for choosing us for your eyecare needs. We are delighted to have you as a patient and appreciate the confidence you placed in us. Please take a moment to complete the following information. Any information we already have on file will appear on this form. ***Please review all completed areas to ensure that the information we have is current and accurate.*** If you have any questions, please do not hesitate to ask.

☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms. ☐ Male ☐ Female

First Name MI Last Name Preferred Name

Street Address City State Zip

Social Security Number Date of Birth Home Phone - Include Area Code Day Phone

Email Address Guardian Person Responsible for Account

Emergency Contact Emergency Phone

PRIMARY INSURANCE INFORMATION

Name and Address of Primary Insurance Company City State Zip

M ☐ F ☐ Insured's First Name MI Insured's Last Name

Insured's Identification Number Group Number Insured's Date of Birth

Patient Relationship to Insured

☐ Self ☐ Spouse ☐ Child ☐ Other

Patient Status ☐ Single ☐ Married ☐ Other

☐ Full Time Student ☐ Part Time Student ☐ Employed

SECONDARY INSURANCE INFORMATION

Name and Address of Secondary Insurance Company City State Zip

M ☐ F ☐ Insured's First Name MI Insured's Last Name

Insured's Identification Number Group Number Insured's Date of Birth

Patient Relationship to Insured

☐ Self ☐ Spouse ☐ Child ☐ Other

Authorization and Release:

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third part payers and/or other health practitioners. I authorize and request my insurance company to pay directly to Dr. John E. Bateman, insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.I am responsible for any & all non-covered services related to insufficient or incorrect insurance information provided to Vision Source/Dr. Bateman or Dr. Carda. I also request payment of government & insurance benefits payable to this office.

Signature of Patient or Parent IF Minor Date

HIPAA COMPLIANCE ACKNOWLEDGEMENT OF RECEIPT

I acknowledged that I received or was offered a copy of John E. Bateman, O.D. Notice of Privacy Practices.

Signature Date

PATIENT HISTORY AND INFORMATION

Name

PRIMARY CARE PHYSICIAN

Primary Care Physician and Clinic Name

Address of Primary Care Physician | City | State | Zip | Phone

REFERRING PHYSICIAN

Referring Physician and Clinic Name

Address of Referring Physician | City | State | Zip | Phone

HEALTH HISTORY

What is the main reason for today's exam ? ____________ When was your last exam ? ________

When was your last health exam ? ________

Past Illnesses or Injuries: ____________

Past Surgeries: ____________

Current Medications: ____________

Current Eye Drops: ____________

Medicines that cause reactions or sensitivities: ____________

Specific Allergies: ____________

EYE HISTORY

Glaucoma	O Yes	O No	Dryness	O Yes	O No	Strabismus (Crossed Eyes)	O Yes	O No
Cataract	O Yes	O No	Excess Tearing/Watering	O Yes	O No	Blurred Vision Distance	O Yes	O No
Macular Degeneration	O Yes	O No	Eye Pain or Soreness	O Yes	O No	Blurred Vision Near	O Yes	O No
Retinal Detachment	O Yes	O No	Foreign Body Sensation	O Yes	O No	Distorted Vision (halos)	O Yes	O No
Color Blindness	O Yes	O No	Infection of Eye or Lid	O Yes	O No	Double Vision	O Yes	O No
Headaches	O Yes	O No	Itching	O Yes	O No	Floaters or Spots	O Yes	O No
Glare/Light Sensitivity	O Yes	O No	Mucous Discharge	O Yes	O No	Fluctuating Vision	O Yes	O No
Tired Eyes	O Yes	O No	Drooping Eyelid	O Yes	O No	Loss of Vision	O Yes	O No
Amblyopia (Lazy Eye)	O Yes	O No	Redness	O Yes	O No	Loss of Side Vision	O Yes	O No
Burning	O Yes	O No	Sandy or Gritty Feeling	O Yes	O No			

GENERAL HEALTH CONDITION

Fever	O Yes	O No	Respiratory (Asthma)	O Yes	O No	Anxiety or Depression	O Yes	O No
Weight Loss	O Yes	O No	Gastrointestinal	O Yes	O No	Thyroid, Diabetes	O Yes	O No
Other Symptoms	O Yes	O No	Kidney	O Yes	O No	Blood/Lymph	O Yes	O No
Ears,Nose,Throat	O Yes	O No	Muscles,Bones,Joints	O Yes	O No	Allergic	O Yes	O No
Cardiovascular (high blood pressure etc.)	O Yes	O No	Skin	O Yes	O No	**Nursing**	O Yes	O No
			Neurological (Multiple Sclerosis)	O Yes	O No	**Pregnant**	O Yes	O No

FAMILY HISTORY

Amblyopia (Lazy Eye)	O Yes	O No	Retinal Detachment	O Yes	O No	High Blood Pressure	O Yes	O No
Blindness	O Yes	O No	Strabismus (Eye Turn)	O Yes	O No	Kidney Disease	O Yes	O No
Cataract(s)	O Yes	O No	Arthritis	O Yes	O No	Lupus	O Yes	O No
Color Blindness	O Yes	O No	Cancer	O Yes	O No	Stroke	O Yes	O No
Glaucoma	O Yes	O No	Diabetes	O Yes	O No	Thyroid Disease	O Yes	O No
Macular Degeneration	O Yes	O No	Heart Disease	O Yes	O No	Others	O Yes	O No

Name

SOCIAL HISTORY

Do you use nutritional supplements (vitamins etc.)? ○ Yes ○ No

Do you engage in regular exercise? ○ Yes ○ No

Do you drink alcohol ? If yes, how much/often : ○ No ○ Occasional ○ 1 Per Day ○ 2-3/day ○ 4+/day

Do you smoke ? If yes, how much/often : ○ No ○ Occasional ○ 1/2 pack/day ○ 1 pack/day ○ 1+ pack

Method of Tobacco Intake : ○ Smoking ○ Chewing

Do you use Illegal Drugs : ○ Yes ○ No

☐ American Indian Or Alaska Native ☐ Native Hawaiian Or Other Pacific Islander
☐ Asian ☐ White
☐ Black Or African American ☐ Declined To Specify
☐ Hispanic Or Latino

Ethnicity ○ Hispanic Or Latino ○ Not Hispanic Or Latino ○ Declined To

Preferred Language ○ English ○ Chinese ○ Dutch; Flemish ○ French ○ German ○ Hindi

Height ft in cm/m ○ ft in ○ cm ○ m **Weight** ○ lbs ○ kg

Release of Records:

We will not disclose protected health information to anyone (**including a spouse**) unless you give us authorization to do so (only exception is parents of minor children). I authorize Eye Specialists to disclose my protected health information (PHI) to:

Name: Relationship:

- ______________________ Expiration date: ___/___/_____
- ______________________ Expiration date: ___/___/_____
- ______________________ Expiration date: ___/___/_____
- ______________________ Expiration date: ___/___/_____

* If no expiration date is given this authorization will automatically expire within 1 year from today's date

PHI to be authorized to disclose: ☐ Medical Record ☐ Health Record ☐ Entire Record