BLUEBONNET
EYE CARE

PATIENT HISTORY FORM

PATIENT INFORMATION

PATIENT NAME: _____

SEX: _____

SOCIAL SECURITY NUMBER: _____

PATIENT ADDRESS: _____

DATE OF BIRTH: _____

MARITAL STATUS: _____

CITY, STATE & ZIP: _____

EMAIL: _____

HOME PHONE: _____

WORK PHONE: _____

MOBILE PHONE: _____

EMPLOYER: _____

OCCUPATION: _____

EMPLOYERS ADDRESS: _____

PRIMARY CARE PHYSICIAN: _____

EMPLOYERS CITY, STATE & ZIP: _____

PRIMARY CARE PHYSICIAN'S PHONE: _____

Medications:

_____

_____

_____

Allergies:

_____

_____

_____

How were you referred to us?

- ☐ Family Doctor
- ☐ Social Media
- ☐ Insurance Company
- ☐ Another Patient

_____

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Do you or your family have any history of the following conditions (check all that apply)?:

Self	Family	
☐	☐	Glaucoma
☐	☐	Cataracts
☐	☐	Diabetes
☐	☐	High Blood Pressure
☐	☐	Macular Degeneration
☐	☐	Heart Problems
☐	☐	Retinal Degeneration
☐	☐	Stroke
☐	☐	Thyroid Condition
☐	☐	Crossed/Lazy Eyes
☐	☐	Asthma/Allergies
☐	☐	Color Blindness
☐	☐	Arthritis
☐	☐	HIV/Hepatitis
☐	☐	Cancer
☐	☐	Neuromuscular
☐	☐	Blindness
☐	☐	Other:

Do you currently have any of the following symptoms (check all that apply):

- ☐ Blurry distance vision
- ☐ Poor night vision
- ☐ Eye Strain
- ☐ Blurry Near Vision
- ☐ Trouble Reading
- ☐ Itchy Eyes
- ☐ Discharge
- ☐ Watering
- ☐ Pain in the eye
- ☐ Burning Eyes
- ☐ Sandy/dry eyes
- ☐ Red Eyes
- ☐ Glare/reflections
- ☐ Discomfort in sunlight
- ☐ Double Vision
- ☐ Floaters or spots in vision
- ☐ Flashes of light
- ☐ Eye injury
- ☐ History of wearing an eye patch
- ☐ History of eye surgery
- ☐ Headaches
- ☐ Dental Abscess

Do you currently have any of the following symptoms (check all that apply):

- ☐ New spectacles
- ☐ A light prescription
- ☐ Light weight glasses
- ☐ Anti-reflective lens
- ☐ Ortho K
- ☐ Colored contact lenses
- ☐ Sunglasses
- ☐ Clip-ons
- ☐ Safety glasses
- ☐ Lasik
- ☐ Contact lenses
- ☐ Dry eye therapy
- ☐ Myopia control

Social History

- ☐ Alcohol use
- ☐ Drug use
- ☐ Tobacco use
- ☐ Other:

_____

BLUEBONNET
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GUARANTOR

GUARANTOR NAME: _____

GENDER: _____

SOCIAL SECURITY NUMBER: _____

ADDRESS: _____

DATE OF BIRTH: _____

CITY, STATE & ZIP: _____

RELATIONSHIP TO GUARANTOR: _____

HOME PHONE: _____

WORK PHONE: _____

PRIMARY VISION INSURANCE:

COMPANY NAME: _____

POLICY NUMBER: _____

POLICY GROUP: _____

INSURED PARTY: _____

SECONDARY VISION INSURANCE:

COMPANY NAME: _____

POLICY NUMBER: _____

POLICY GROUP: _____

PRIMARY MEDICAL INSURANCE:

COMPANY NAME: _____

POLICY NUMBER: _____

POLICY GROUP: _____

INSURED PARTY: _____

SECONDARY MEDICAL INSURANCE:

COMPANY NAME: _____

POLICY NUMBER: _____

POLICY GROUP: _____

INSURED PARTY: _____

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MEDICAL INSURANCE POLICY:

As a part of our services at this practice we are happy to assist you in determining the benefits of your individual polity and in collecting your reimbursement of insurance benefits for medical services. To avoid any misunderstandings please read the following statements carefully.

1. The legal obligations of your insurance provider are between yourself and your provider, not between this practice and your provider.
2. When your insurance provider has settled your plan's covered items, you will be notified by a monthly statement if there were any unpaid balances. Unpaid balances can include non-covered items or services co-pays, deductibles, lapses, ineligibility or termination of coverage's. Unpaid balances are the sole responsibility of the patient.
3. To keep the cost of records and collections down any patient portion amounts on your order will be due at the time of service.
4. I authorize the use of this form on all insurance submissions as well as authorizing the release of information to all my insurance companies as well as allowing the doctor to act as my agent to help me in obtaining payment from my insurance companies.
5. I authorize payment to be made directly to the provider and permit a copy of this authorization to be used in place of the original.

REFUND/RETURN POLICY:

No refund can be made on clinical procedures or services, including comprehensive eye examination, refraction, contact lens fitting, and medical office visits. Refunds for optical products, which include frames, and unopened boxes of contact lenses can only be made within 30 days of receiving the product, provided that the product is returned to the store without damage at the time that the refund is issued. Opened boxes of contact lenses arc non-refundable. After the 30 day period, only 50% of the original payment made by the patient (private-pay or with insurance) can be issued back to the patient as store credit with the return of the product. 90 days after a product is dispensed, no refund, no return, no exchange, no return can be made on any goods purcuased at this store.

CONSENT FOR TREATMENT:

I hereby authorize Bluebonnet Eye Care to administer diagnostic and medical procedures as may be necessary for proper healthcare.

_____ _____

Signature of patient or authorized representative Date

HIPAA CONSENT

_____

Authorized representative's name

BLUEBONNET
EYE CARE

CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

Permission to Use and Disclose My Hea1th Information: By signing this form, I give Bluebonnet Eye Care permission to use and/or disclose my health information to provide treatment, obtain payment, and/or conduct health care operations.
R**ight to Refuse**: I have the right not to sign this consent. If I refuse to sign this consent, Bluebonnet Eye Care has the right to refuse to treat me. However, treatment required by law - such as emergency care - can be provided to me whether or not I sign this consent.
Changes to the Notice of Privacy Practices: Bluebonnet Eye Care may change the Notice of Privacy Practices as needed. I may obtain a current copy of the Notice of Privacy Practices for Bluebonnet Eye Care by contacting Bluebonnet Eye Care.
Right to Request Restrictions on Use/Disclosure: I have the right to request that the usage of my protected health information by Bluebonnet Eye Care is restricted in how it is used and/or disclosed for the purpose of providing treatment, obtaining payment, and/or conducting health care operations. However, Bluebonnet Eye Care is not required to agree to any restriction I request. If Bluebonnet Eye Care does decide to agree to my request, the use and/or disclosure of my health information by my Bluebonnet Eye Care must be restricted as I requested. If I wish to request restrictions I can contact Bluebonnet Eye Care. Bluebonnet Eye Care will notify my on whether my restrictions have been accepted or declined.
Right to Withdraw Consent: I have the right to withdraw this consent at any time. I must do so in writing by contacting Bluebonnet Eye Care at 9823 W. IH-10, San Antonio, TX 78230. My withdrawal of this consent will not be effective for uses and/or disclosures that have already been made based on my prior consent. If I withdraw this consent, then Bluebonnet Eye Care may refuse to provide to me further treatment or follow-up, other than required emergency services.
Effective Period: This consent is good unless and until I withdraw it in writing.
References to "I" or "me": References to "I" or "me" in this Consent include the individual for whom the signing party is authorized to sign. If I am signing this consent on behalf of another person, it is because I am that person's parent, legal guardian, or agent under an active Power of Attorney for Health Care; and I am legally authorized to sign this Consent on behalf of that person.

_____ _____
Signature of patient or authorized representative Date

_____
Authorized representative's name

FOR OFFICE USE ONLY

Complete this section if this form is not signed and dated by the patient or an authorized representative for the patient.
I have made a good faith effort to obtain a written acknowledgement of the receipt of the Notice of Privacy Practices for Bluebonnet Eye Care but was unable to for the following reason:

- ☐ Patient refused to sign
- ☐ Patient is unable to sign
- ☐ Other _____

_____ _____
Signature of patient or authorized representative Date

_____
Authorized representative's name