Welcome to our Office
BOWMAN OPTOMETRY

Please present insurance card and photo ID for us to copy

☐no insurance cards presented

PLEASE PRINT

NAME:
(Mrs. Ms.,Miss,Mr.,Dr.,Prof)______________________________ Nickname:______________

ADDRESS:____

CITY:_____________________ **STATE:**______________ **ZIP:**__________

HOME PHONE #:__________________ **EMAIL:**_____________________

CELL PHONE #__________________ **MAY WE SEND YOU A TEXT:** YES_____ NO______

DATE OF BIRTH:__________ ☐Female ☐Male **SOCIAL SECURITY NUMBER** XXX-XX-__ __ __ __

RACE: ☐ AFRICAN AMERICAN ☐ASIAN ☐CAUCASIAN

☐NATIVE HAWAIIN OR PACIFIC ISLANDER ☐AMERICAN INDIAN OR ALASKA NATIVE

ETHNICITY: ☐HISPANIC ☐NON-HISPANIC ☐DECLINED **LANGUAGE:** ☐English ☐other______

Do you wear Contact Lenses now?☐Yes ☐ No **Are you interested in Contact Lenses:**☐Yes ☐ No

Have you had LASIK surgery?☐Yes ☐ No If so when?____Are you interested in LASIK☐Yes☐No

VISION INSURANCE

Vision Insurance Company__________________________ Subscriber's Name:______________

Date of Birth________SS#________ Relationship to Subscriber(Please circle) : spouse partner child

HEALTH INSURANCE

Health Insurance Company________________________ Subscriber's Name:________________

Date of Birth______________ relationship to Subscriber(Please circle) spouse partner child

I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

Your Signature:__________________________________ **Date:**________________

We are grateful for the chance to serve you and we appreciate you being our patient!

Medical History Questionnaire

Patient's Name:____ **Date of Birth:**________________

Date of Last Physical:________________ **Date of Last Eye Exam:**_________________

Which of the following conditions are you currently being treated or have been treated for in the past (please check)

☐Heart disease/Murmur/Angina	☐Shortness of breath	☐Eye disorder/glaucoma	☐Diabetes
☐High cholesterol	☐High Blood Pressure	☐Asthma	☐Seizures
☐Lung problems/cough	☐Stroke	☐Sinus problems	☐Headaches/migraines
☐Arthritis	☐Heartburn (reflux)	☐Seasonal allergies	☐Neurological problems
☐Cancer	☐Depression/anxiety	☐Ulcers/colitis	☐Fevers
☐Anemia/blood problems	☐Thyroid problems	☐Skin Disease	☐Immunological Disease

☐Extreme weight loss or gain ☐Any private health information you would prefer to discuss with you doctor

Please describe any current or past medical treatment not listed above: ______________________________

____

Do you have/had any of the following eye conditions: ☐Crossed eyes ☐Lazy eye ☐Glaucoma

☐Drooping eyelid ☐Retinal Disease ☐Cataracts ☐Eye injury ☐Eye surgery

Details/other____

Allergies: Are you allergic to penicillin or any other drugs? ☐Yes ☐ No Latex? ☐ Yes ☐ No

Please list:____

____

Are you on any medications? ☐ Yes ☐ No

Please list:____

____

Females:

Are you pregnant : ☐ Yes ☐ No

Are you nursing: ☐Yes ☐ No

Social and Preventive History:

Do you currently smoke or chew tobacco? ☐Yes ☐ No If no, have you in the past? ☐Yes ☐No
How many packs per day? ________________________

Do you drink alcohol, beer or wine? ☐ Yes ☐No
How many drinks per week? ______________________

Has any member of your family members (parents, grandparents, siblings or children) had any of the following illnesses:

Illness	Which family member?
Blindness	
Glaucoma	
Cataracts	
Retinal Detachment	
Macular Degeneration	
Diabetes	
High Blood Pressure	
Cancer	

By signing below, I hereby certify that to the best of my knowledge all the information on this form is complete, true and accurate.

Patient/Parent/Legal Guardian Signature____________________________________ **Date**_______________

Physician's Signature____ **Date**_______________

BOWMAN OPTOMETRY

Authorizations and Acknowledgments

Insurance Information

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Please ask us if you have any questions about our fees, financial policy, or your payment responsibility.

- All new patients will be asked to provide patient information prior to being seen by the doctor. We will also ask to make a copy of any type of picture identification and insurance cards to remain a permanent part of your chart.
- If you are covered by Medicare or any of our managed plans, we will file your insurance claim. You are responsible for any co-pay, co-insurance, deductible or any non-covered services at the time of your visit. If we do not participate with your insurance company, you will be responsible for full payment at the time of your visit. **Methods of Payment: Cash, Check, Visa, MasterCard, Discover and American Express.**
- All self-pay patients are expected to pay for services in full at the time that services are rendered
- In the event your insurance company does not pay the full balance within 90 days, we will notify you so that you may contact you insurance carrier. Please remember that ultimately, payment responsibility rests with the patient.
- Please advise the office personnel of any changes in your insurance or mailing address.
- Should it ever become necessary to use the services of a collection agency to collect your account, you would be responsible for any costs for that purpose.

Authorizations for Payment

I hereby authorize Bowman Optometry to bill my insurance company directly for these services. I understand I am financially responsible for charges not covered by my insurance company. I authorize any holder of medical or other information about me to release to the Social Security Administration or intermediaries any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical benefits either to myself or to the party who accepts assignment. I certify that my information is currently correct.

Responsible Party Signature ______________________ Date ____________

Patient's Name (Please Print) ______________________ Date of Birth ____________

Notice of Privacy Practices

I acknowledge receipt of a copy of the Bowman Optometry Notice of Privacy Practices either at this time or previously. By accepting services at Bowman Optometry, I authorize Bowman Optometry to use and disclose information from and release copies of my (the patient's) medical records in accordance with Bowman Optometry policies and privacy practices, which are summarized in the Notice of Privacy Practices, including disclosure to my (the patient's) past, present and future healthcare providers.

Patient or Parent (Guardian) ______________________ Date ____________