bella vision
FAMILY VISION CARE

medical history questionnaire

1855 East Main Street - Suite 12 - Spartanburg - SC - 29307
864.308.8812 voice www.bella-vision.com web

Date

Patient's Name | Date of Birth | Age

Street Address | City | ST | Zip

Ethnicity | Gender ☐ Male ☐ Female

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widow

If Married, Name of Spouse | If Child, Parent's Name

Phone | Business Phone | Cell Phone

E-Mail | Patient's Social Security No.

Employer | Occupation

---

insurance information (if applicable)

Insured Social Security No.

Insured Date of Birth

Name of Medical Insurance | Relationship to Insured

Primary Insured | Subscriber Social Security No.

Name of Vision Insurance | Subscriber Date of Birth

Name of Primary Care Physician | Last Medical Exam

Date of Last Eye Exam

Reason For Today's Visit

Are You Having Any Problems With Your Current Glasses or Contact Lenses? ☐ Yes ☐ No

Are You Wearing Contact Lenses? ☐ Yes ☐ No Are You Interested In Contact Lenses? ☐ Yes ☐ No

Current Brand / Power of Contact Lenses:

Review of Systems	Yes	No	Family
Allergies	☐	☐	☐
Arthritis	☐	☐	☐
High Blood Pressure	☐	☐	☐
Heart Disease/Problems	☐	☐	☐
Diabetes	☐	☐	☐
Gastrointestinal	☐	☐	☐
Cancer	☐	☐	☐
Endocrine/Thyroid	☐	☐	☐
Ear/Nose/Throat	☐	☐	☐
Headaches	☐	☐	☐
Urinary/STD	☐	☐	☐
Blood/Lymph Nodes	☐	☐	☐
Psychiatric	☐	☐	☐
Respiratory	☐	☐	☐

Ocular History	Yes	No	Family
Blurred Vision	☐	☐	☐
Cataracts	☐	☐	☐
Crossed Eye	☐	☐	☐
Double Vision	☐	☐	☐
Eye Infections	☐	☐	☐
Eye Injury/Trauma	☐	☐	☐
Flashes/Floaters	☐	☐	☐
Glaucoma	☐	☐	☐
Macular Degeneration	☐	☐	☐
Retinal Disease	☐	☐	☐
Retinal Detachment	☐	☐	☐
Surgery	☐	☐	☐
Tearing	☐	☐	☐
Tired Eyes	☐	☐	☐

Please Explain Any **YES** answers:

ALLERGIES drug,seasonal food

CURRENT MEDICATIONS (Rx and over the counter, including eye drops):

Please List any **hospitalization, major surgeries** or **illnesses** (date and type):

Social History (all information is kept strictly confidential):

Do you smoke? ☐ Yes ☐ No If yes, how often?

Do you drink alcohol? ☐ Yes ☐ No If yes, how much?

Are you pregnant? ☐ Yes ☐ No ☐ Nursing

How Did You Lear About Our Practice?

☐ Established Patient ☐ Insurance ☐ Media (Facebook, Twitter)

☐ If referred, by whom?

Informed Consent To Dilate The Eyes
Dilating drops are used to enlarge the pupil of the eye to allow a more thorough exam of the eye. Side effects of dialtion may include blurred vision and mild light sensitiviy, which may last for 2-4 hours. Bright light may also be bothersome; however, disposable sunshields are given at the completion of the exam. Dilation is included in the exam fee. In certain circumstances, the doctor may defer dilation.

Please select:

☐ I hereby authorize the administration of dilation drops

☐ I will reschedule dilation for a later date

☐ I do not wish to have my eyes dilated

Please Initial The Following:

_____ **Consent For Care**

I hereby give consent for treatment to Bella-Vision.

_____ **Polycarbonate Lenses**

Polycarbonate lenses are the most impact resistant lenses available. They are strongly recommended for patients with compromised vision in one eye, patients who are active in sports, patients who work with power tools and patients under the age of 18.

_____ **Authorization To Leave Message**

I hereby authorize Bella-Vision to leave messages regarding pending appointments, tests, glasses or contact lenses at the numbers given.

_____ **Acknowledgement Of Receipt Of Notice Of Privacy**

I have been given the opportunity to read the Notice of Privacy Practices as required by HIPPA Privacy Regulations.

_____ **Insured Authorization/Payment Guarantee**

I authorize the release of any medical or other information necessary to process this claim. I authorize payment of medical benefits to the physician or supplier of services.

I agree that I am solely responsible for all charges related to my visit. I understand that I am responsible for any and all balances due after insurance payments have been applied. I understand that I am responsible for all fees and legal expense related to the collection of my balance. I understand that there is a $35.00 return check fee.

Signature of Patient/Guardian _____ Date _____

Doctor's Signature _____ Date Updated _____ Initials _____

Print Form