

Welcome to Bella Optical

All information is confidential and will only be used by this office

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|--|---------------------------|
| Patient Information | |
| Name: | Patient Birth Date: |
| Address: | |
| City: | State: Zip: |
| Occupation: | Employer: |
| Home Phone: | Work Phone: |
| Spouse's Employer: | |
| Insurance Information | |
| Primary Insurance Company: | |
| Insurance ID Number: | |
| Subscriber Name: | Birth Date: |
| Relationship to Subscriber (Please circle one): Self Spouse Dependent Child | |
| Last Eye Exam Date: | Name of Doctor/ Location: |

Patient History:

What type of work do you do? _____

Do have any hobbies? _____

Are you active in sports? _____

Are you sensitive to light? _____

Are you having any problems with your present _____

Eyeglasses or contacts? _____

Do you work at a computer terminal? Hours per day? _____ Yes No

Do you or any family member have Diabetes? Who? _____ Yes No

Do you have any medical problems?..... Yes No

Describe: _____

Do you take medication?..... Yes No

List: _____

Do you have frequent headaches?..... Yes No

Do you see double? Yes No

Do you or any family member have Glaucoma? Who? _____ Yes No

Do you or any family member have Cataracts? Who? _____ Yes No

Does any family member have an eye disease?..... Yes No

Describe: _____

Have you ever had any eye disease, injury or surgery? Yes No

Describe: _____

I authorize the release of any medical or other information to process my insurance claims. I also authorize payment of medical benefits to my Doctor. It is my understanding that I am responsible to obtain all referrals that my insurance company requires for services performed by the Doctor. I understand that I am responsible for any charges not covered by my insurance. I was given the chance to review "Notice of Privacy Act".

Please help us "Go Green" by providing us with your e-mail address:

E-mail address: _____

Patient Signature: _____ Date: _____