Name | DOB | Age

Address | City | Zip

Primary Phone | Alt Phone | E-Mail

Employer | Occupation | SSN

Insurance Information

Medical Insurance Plan | ID#

Vision Insurance Plan | ID#

Primary Insured Name | Primary Insured DOB

Medical History

Date of Last Eye Exam | Date of Last Medical Exam

Current Medications

Allergies

Surgeries

Do You ☐ Smoke ☐ Drink Alcohol **Are You** ☐ Pregnant ☐ Nursing

☐ Do You Currently Wear Contact? If so, what brand?

☐ Do You Wear Glasses? If so, what brand?

Do you have any complaints about your glasses/contacts?

Have you or a family member ever been diagnosed with Glaucoma, Macular Degeneration, Cataracts, or any other eye diseases/problems?

Have you or a family member ever been diagnosed with cancer, diabetes, high blood pressure, thyroid disease, high cholesterol, arthritis, or headaches?

What is the primary reason for your visit today?

How did you hear about us?

Please Continue to Page 2 of Intake

Your signature authorizes us to bill your insurance company for services and materials provided. We make every attempt to verify benefits before your appointment. In the event that you have not met your deductible, or are otherwise denied by your insurance, we have the right to collect payment from the responsible party.

Signature _____ Date [ ]

To designate another party to receive your health information – If your request for access of your health information directs us to transmit a copy of the health information directly to another person, the request must be made by you in writing to the address below and must clearly identify the designated recipient and where to send the copy of your health records.

To receive an accounting of disclosures of your health information – you must make such requests in writing to the address below. Not all health information is subject to this request. Your request must state time period for records you would like to receive no longer than six (6) years prior to the date of your request. Your request must state how you would like to receive the report (paper or electronically).

Dilation Consent

Dilation is a medical procedure during which drops are placed in the eyes to enlarge the pupils. This allows our doctors to have a more complete view of the retina. Early signs of eye disease are best detected when the pupils are dilated. For this reason, dilation is recommended and done annually for no additional charge. Dilation side effects include light sensitivity and blurry vision up close. If you opt to be dilated, temporary sun shields will be provided for you.

◯ I accept dilation ◯ I do not want to be dilated

Retinal Imagining

For a more complete view into the ocular health of your eye, retinal images are taken of the internal structures of the eye. Images captured bu the camera serve as screenings for cardiovascular, intracranial, autoimmune, and infectious diseases that may affect the rest of the body. To monitor changes in ocular health from year to year, our doctors recommend annual retinal imaging for all patients. Insurance companies do not cover the cost of this screening because it is considered preventative care.

THE ADDITIONAL COST IS $20

◯ I accept retinal imaging. ◯ I do not want to have my retinal image taken.

Complaints

If you feel we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to this office, or if you prefer to discuss your complaint over the phone.

Brightside Eye Care
6045 Hagen Ranch Rd Suite #5
Lake Worth, FL 33467

Acknowledgment of Receipt

I acknowledge that I have received a copy of the privacy practices of Brightside Eye Care.

Name [ ] Signature _____ Date [ ]

WE RESERVE THE RIGHT TO CHANGE PRIVACY PRACTICES, COPIES ARE AVAILABLE UPON REQUEST.