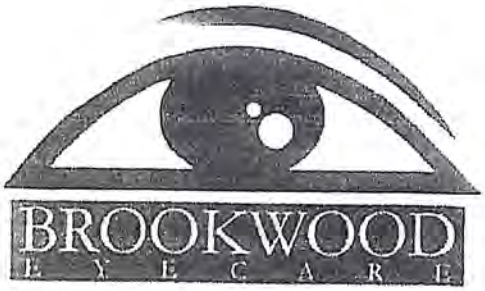

Welcome To Our Office

Gender: (Please circle one): M F Date: _____ How you found our Office: _____

Patient **Last** Name: _____ Patient **First** Name: _____ Pat. DOB _____

Insurance Subscribers Last Name: _____ First Name: _____ DOB _____

Address: _____

City _____ State _____ Zip Code _____

HomePhone: _____ Work: _____ Cell: _____

E-mail: _____ (please print each alphabet separate & legibly)

Insurance Subscribers **Member ID** # or Last four of **SSN**: _____

Groupon # or Self Pay: _____ **Vision Insurance:** _____

Insurance Authorization: I authorize and request my insurance company to pay to the eye doctor benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for service. I agree to be responsible for the payment of all services rendered on my behalf or my dependents.

Signature: _____ Date: _____

HIPAA PRIVACY ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE:

I, _____ (Please print name of patient or legal representative) have been presented with the Notice of Privacy Policy of Dr. Birdsong & Associates (the Provider), and have been offered a copy of such policy to keep for records.

Please check one:

_____ I hereby acknowledge receipt of the policy.

_____ I hereby REFUSE to acknowledge receipt of the policy. I understand that even though I refuse to sign this ACKNOWLEDGEMENT, the Provider may still provide treatment to me.

Signature: _____ Date: _____

BROOKWOOD EYECARE

____/____/____

FULL NAME_____

DATE OF BIRTH_____

PATIENT MEDICAL HISTORY

Name of physician_____
City_____
Last date of check up_____

CURRENT MEDICATIONS

(List the names of medications including eye drops, vitamins, and birth control pills)

_____

_____

Any allergies to medication? YES NO
If so, what medications?

_____

_____

Have you had any surgeries? YES NO
Do you use cigarettes/tobacco, alcohol, or other substances? YES NO

Have you ever been diagnosed or treated for any of the following health problems?

Allergies	YES NO
Arthritis	YES NO
Blood/Lymph	YES NO
Bronchitis	YES NO
Cancer	YES NO
Cholesterol	YES NO
Diabetes	YES NO
Digestive/Ears/Nose/Throat	YES NO
Endocrine	YES NO
Eczema/Rashes	YES NO
Genitourinary	YES NO
High Blood Pressure	YES NO
Integumentary (Skin)	YES NO
Kidney	YES NO
Muscle/Bone	YES NO
Neurological	YES NO
Psychological	YES NO
Respiratory/ COPD/ Asthma Etc.	YES NO
Sinus	YES NO
Throat Infections	YES NO
Thyroid	YES NO
Unusual Wight Losses/Gains	YES NO
Currently Pregnant?	YES NO

PATIENT EYE HISTORY

Date of last eye exam_____
Do you currently wear glasses? YES NO
Do you currently wear contacts? YES NO
What kind?_____
Solution used?_____
Are you satisfied with the vision, and comfort of your contact lenses? YES NO
Would you prefer clear, or colored contacts?
☐ Clear ☐ Colored ☐ Both
Do you use the computer? YES NO ___#hours

Occupation:_____
List any hobbies you may have in which clear vision is important

_____

_____

Have you ever experienced been diagnosed or treated for any of the following?

[ ] Blurry Vision [ ] Burning [ ] Itchiness
[ ] Grittiness [ ] Corneal abrasion
[ ] Crossed Eye/Eye Turn [ ] Lazy Eye
[ ] Double Vision [ ] Eye Infections
[ ] Eye injury [ ] Flashes of Light
[ ] Floaters/Spots [ ] Cataracts
[ ] Glaucoma [ ] Headaches
[ ] Sunlight Sensitivity [ ] Iritis/Uveitis
[ ] Macular Degeneration [ ] Dry Eyes
[ ] Retinal Detachment [ ] Tearing
[ ] Trouble seeing at night?
[ ] Other eye disorder(s)_____

FAMILY EYE/MEDICAL HISTORY

Is there a family medical history of any of the following list (Please circle, and list relationship)

Blindness	Yes	No	Who:_____
Cataracts	Yes	No	Who:_____
Corneal Problems	Yes	No	Who:_____
Diabetes	Yes	No	Who:_____
Glaucoma	Yes	No	Who:_____
Heart Disease	Yes	No	Who:_____
Lazy Eye	Yes	No	Who:_____
Retinal Problems	Yes	No	Who:_____

Sign: _____

SAFETY PRECAUTIONS REGARDING CORONVIRUS / COVID19

In order to assure your safety as well as the safety of the doctors and staff, we urge you to please answer the following questions to the best of your recollection.

1. Have you travelled outside the United States in the last 3 months to the following areas?
   (Mainland China and its provinces) Y N

2. Have you come in close contact with anyoune who has travelled to any of the above mentioned areas? Y N

3. Are you currently experienceing or have experienced the following symptons in the last 10 – 14 days? Coughing, shortness of breath, fever, upper respirator infections? Y N

4. Are you also exerienceing light sensitivity, redness and irritation of the eyes? Y N

On behalf of our doctors and staff here at Brookwood Eyecare,
We appreciate your continued support. Thank you!

optomap®
ultra-widefield retinal imaging

We pride ourselves on providing our patients with the best possible standard of care. **Because of this, we now perform the optomap® Retinal Exam with all of our patients.** When reviewed, the scan becomes a permanent part of your medical file, enabling the doctor to make important comparisons should potential vision threatening conditions show themselves at a future examination. **The Doctors at Brookwood Eye Care prescribe the Optomap Retinal Exam as part of your comprehensive eye exam.**

As part of your pre-test work up, we will capture optomap® images for review with the doctors during your examination today. There is a $39 co-pay for the Optomap with your insurance. Any questions you have about the optomap® Retinal Exam can be directed to doctor when he reviews the images with you during your examination.

DILATION with Drops

Similar to Optomap, lets the Doctor obtain a wide view of inside the eye. TYPICALLY NOT RECOMMENDED IF PREGNANT. It requires drops, 20 mins wait time period, and the side effects are light sensitivity and blurriness (mainly at near) for about 4 hours. Recommended and will be performed in instances where the doctor seems it necessary such as sudden onsetof flashes or floater. May also be performed alongside an optomap photo.

I have read and understand this document:

Sign: _____ Date: _____

BROODWOOD EYE CARE

OFFICE POLICIES

We look forward to providing all your vision care needs, and will go above and beyond to provide excellent customer service. Please take a moment to review our policies.

1). Contact Lens Rx's are **valid for 1 year** per FDA regulations. Evaluations are required annually.

2). All Contact Lense Patients are automatically prescribed back up prescription glasses.

3). All fittings for Contact Lense examinations are to be completed within sixty (60) days to prevent any additional fitting fees.

4). Doctor's Rx changes are done one time at no charge within 60 days of initial order date.

5). There are **no warranties on sale/clearance frames** unless purchased in addition.

6). Patient's own frame: We take great care in the process of fitting new lenses into a customer's old frame, making adjustments, or minor repairs. But we are not responsible for breakages during these processes. **Please know that these are done at your own risk.**

7). Refunds: Because glasses are individually fabricated, we are unable to entertain requests for refunds, therefore **All Sales are Final**. Merchandise may be returned within 30 days for exchanges or store credits.

8). All contact Lense and Spectacle Glasses Orders are to be picked up within 60 days from the date of purchase. Orders not picked up within 60 days will be returned to the lab and any payments and deposits may be forfeited.

9). All frames placed on hold will be returned back to the display case for sale after two (2) weeks.

Insurance Authorization

☐ I authorize and request my insurance company to pay to the eye doctor benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for service. I agree to be responsible for the payment of all services rendered on my behalf or my dependants.

☐ I acknowledge and agree to all of the above policies and receive services.

Signature: _____ **Date:** _____