LISA BISSESSAR, OD, P.A.

PATIENT INFORMATION

Date _____ SS# (last 4) _____ DOB _____/_____/_____ Gender _____ Age _____

Last Name _____ First Name _____ Middle Initial _____

Title □ Dr. □ Master □ Mr. □ Miss □Ms. □ Mrs. Race _____ Ethnicity _____ Marital Status □ M □ D □ S □W

Address _____Apt. # _____ City _____ State _____ Zip _____

Primary Phone _____ Email _____

Employer/School _____ Occupation/Grade _____

General Physician _____ Last Visit _____

Person to contact in case of emergency _____ Phone _____

Pharmacy and Address _____ Phone _____

Name of Last Eye Doctor_____ Last Exam _____

INSURANCE INFORMATION

Primary Insured _____ Relationship to patient _____

Employer _____ DOB _____-_____-_____ SS# _____/_____/_____

Insurance Co _____ Insurance ID _____

ASSIGNMENT AND RELEASE OF INSURANCE INFORMATION

I, the undersigned, certify that I (or my dependent) have insurance with the above and assign directly to Lisa Bissessar, OD, P.A**.** insurance benefits, if any, otherwise payable to me for service rendered. I understand that I am financially responsible for all charges whether paid by insurance or not. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions*. (If the insurance has not paid within 60 days, you will be notified. If we do not take your insurance, talk to your insurance about submitting our superbill for reimbursement*.)

FINANCIAL RESPONSIBILITY

Full payment is required at the time of service. Any check returned will be assessed an additional $25.00 fee. Any balance unpaid will be turned over to a collection agency after notification. We request a copy of your drivers license for our records if you wish to make payments by check. We accept Visa/Amex/MC/Disc/Cash/Checks.

FOLLOW UP AND REFUND POLICY

All services rendered by the doctor are non-refundable. Patients have 90 days follow-up from the date of the exam to make any changes to the prescription if necessary or to reschedule a dilation. If the patient chooses to follow up or dilate after the allotted period, then additional charges will apply.

REFRACTION

The refraction is the process of determining the eyeglasses or contact lens prescription with a series of lens choices. All vision insurance will cover this in the routine exam. Medicare, however, does not approve this part and an additional charge will apply.

MINOR PATIENTS (Patients under 18)

The adult (parent/guardian) accompanying a minor is responsible for full payment at the time of service. The parent or guardian signing this form gives consent to the office of Lisa Bissessar, OD, P.A**.** to provide eyecare products and services to said minor. In the case of contact lens wear, the parent or guardian understands the risks and responsibilities of contact lens use.

RECEIPT OF NOTICE OF PRIVACY PRACTICES

The HIPPA act requires our office to provide you a copy, or access to our Notice of Privacy Practices. The Notice of Privacy Practices describes in detail how your health information will be used and disclosed, and how you can access your information. By signing below, you have acknowledged you have received a copy of the Notice of Privacy Practice of the office of Lisa Bissessar, OD, P.A.

I HAVE READ, UNDERSTOOD AND COMPLETED THIS FORM TO THE BEST OF MY KNOWLEDGE.

Patient/Guardian Signature _____Date_____

Reason for your visit today _____

Are you interested in? Contact Lenses _____ Laser surgery to correct your vision _____

Do you wear glasses? Always _____ only when driving _____ for reading _____ sunglasses _____ computer _____

Do you wear Contacts? Disposable soft _____ Gas permeable (hard) _____ Brand _____

Current medications _____
Eye drops _____
Eye surgeries_____
Other surgeries _____
Allergies _____

PATIENT EYE HISTORY

Y/N Cataract	Y/N Glaucoma	Y/N Lazy Eye	Y/N Redness	Y/N Eye Injury
Y/N Corneal Dystrophy	Y/N Retinal Tear	Y/N Floating Spots	Y/N Vision Field Loss	Y/N Bells Palsy
Y/N Macular Degeneration	Y/N Narrow Angle	Y/N Eye Pain	Y/N Eye Strain	Y/N Light Sensitive
Y/N Dry Eyes	Y/N Retinopathy	Y/N Tearing	Y/N Blurry Vision	Y/N Double Vision

PATIENT MEDICAL HISTORY: Do you have any problems in the following areas?

Y/N Jaw Pain	Y/N Stroke	Y/N Seizures	Y/N Hepatitis	Y/N Headache
Y/N Scalp Tenderness	Y/N COPD	Y/N High Blood Pressure	Y/N Cancer	Y/N Anemia
Y/N Arthritis	Y/N Depression	Y/N HIV	Y/N Fever	Y/N Allergies
Y/N Asthma	Y/N Diabetes	Y/N Cholesterol	Y/N Dry Mouth	Y/N Multiple Sclerosis
Y/N Heart Problems	Y/N Kidney Disease	Y/N Thyroid	Y/N Lupus	Y/N Pregnant/Nursing

FAMILY EYE HISTORY: None_____, Blindness_____, Glaucoma _____, Macular Degeneration _____, Other _____

FAMILY MEDICAL HISTORY: None_____, Diabetes _____, High Blood Pressure _____, Autoimmune _____, Other _____

PATIENT SOCIAL HISTORY: None _____, Smoke/Amount_____, Drink/Amount_____, Street Drugs/Amount_____

Dilation: In order to fully examine your eye health, it is necessary to dilate your pupils. Dilation requires the use of drops that may make your vision blurry and or sensitive to light for 3-7 hours. Dilation is recommended yearly but is not necessary to get an eyeglass or contact lens prescription. Dilation is included in your exam and there is no additional charge for this.

□ **Yes**, I authorize doctor to dilate my eyes today for a more comprehensive component of my eye health records.

□ **No**, I choose not to dilate today.

Retinal Photos: A highly specialized digital camera is used to capture images of the central and peripheral retina, optic nerve and macula. Fundus photographs are used to document abnormalities associated with cancer, diabetic retinopathy, macular degeneration, glaucoma, hypertensive changes, retinal detachments etc.) The photographs become part of your permanent record and will be interpreted and reviewed with you during the eye exam by the doctor. Photos are recommended yearly, and there is an additional charge.

□ **Yes**, I choose to have retinal photography today as a more comprehensive component of my eye health records.

□ **No**, I choose to defer the retinal photography today.

I HAVE READ, UNDERSTOOD AND COMPLETED THIS FORM TO THE BEST OF MY KNOWLEDGE.

Patient/Guardian Signature _____ Date _____