



PREMIER FAMILY VISION
N.P. Bhadra, OD & Associates, PC

LAST NAME _____ FIRST _____ MI _____ DATE _____

ADDRESS _____ CITY, STATE _____ ZIP _____

SS# _____ BIRTHDATE _____ AGE _____ M / F

EMPLOYER _____ INSURANCE CO. _____

HOME PHONE _____ WORK PHONE _____

CELLPHONE _____ E-MAIL _____

24-48 HR PRIOR NOTICE IS REQUIRED FOR ANY INSURANCE VERIFICATION PRIOR TO SERVICES RENDERED

REFERRED BY _____ LAST EXAM _____ FROM DR. _____

HAVE YOU EVER WORN GLASSES? Y/N IF SO, FOR: DISTANCE/NEAR/CONSTANT

HOBBIES _____

REASON(S) FOR TODAY'S VISIT:

- | | | |
|--|---|---|
| <input type="checkbox"/> GENERAL CHECK UP | <input type="checkbox"/> EYE PAIN | <input type="checkbox"/> POOR NIGHT VISION |
| <input type="checkbox"/> LOST/BROKEN GLASSES | <input type="checkbox"/> SEEING SPOTS | <input type="checkbox"/> WANT CONTACTS |
| <input type="checkbox"/> BLURRED DISTANCE VISION | <input type="checkbox"/> EYES BURN/ITCH | <input type="checkbox"/> PROBLEM W/CONTACTS |
| <input type="checkbox"/> BLURRED NEAR VISION | <input type="checkbox"/> HEADACHES | <input type="checkbox"/> GLARE |
| <input type="checkbox"/> OTHER (SPECIFY) _____ | | |

DO YOU WEAR CONTACTS? Y / N TYPE: _____

DO YOU TAKE ANY MEDICATIONS? Y/N PLEASE LIST: _____

- | | | |
|--|---|-----------------------------------|
| <input type="checkbox"/> DIABETIC MEDICINE | <input type="checkbox"/> BLOOD PRESSURE MED | <input type="checkbox"/> STERIODS |
| <input type="checkbox"/> ANTIHISTAMINES | <input type="checkbox"/> BIRTH CONTROL | <input type="checkbox"/> PREMARIN |

HAVE YOU BEEN SEEN IN THIS OFFICE BEFORE?

Yes No

DO YOU OR ANY FAMILY MEMBERS HAVE: IF SO, WHO?

- | | | |
|---|--|--|
| <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> DIABETES | <input type="checkbox"/> HEART DISEASE |
| <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> ALLERGIES (TO: _____) | |
| <input type="checkbox"/> MACULAR DEGENERATION | <input type="checkbox"/> GLAUCOMA | <input type="checkbox"/> CATARACTS |
| <input type="checkbox"/> COLOR VISION PROBLEMS | <input type="checkbox"/> DOUBLE VISION (WHEN: _____) | |
| <input type="checkbox"/> EYE INFECTIONS, INJURY, OR SURGERY (TYPE: _____) | | |

PLEASE READ AND INITIAL BELOW:

WE MAY NEED TO INSTILL DROPS TO EXAMINE THE EYES. THESE DILATING DROPS MAY CAUSE BLURRED VISION AND SENSITIVITY TO LIGHT.

- YES, I GIVE PERMISSION FOR DIAGNOSTIC DROPS TO BE USED IN MY EYES.
 NO, I DO NOT GIVE PERMISSION FOR DIAGNOSTIC DROPS TO BE USED IN MY EYES.

- YES, I DO GIVE AUTHORIZATION FOR TREATMENT.
 YES, I DO ACKNOWLEDGE I HAVE BEEN GIVEN ACCESS TO THE NOTICE OF PRIVACY
 YES, I DO GIVE AUTHORIZATION FOR PREMIER FAMILY VISION TO FILE FOR ANY INSURANCE BENEFITS.
 YES, I DO UNDERSTAND, IN THE EVENT MY INSURANCE DOES NOT PAY, I AM RESPONSIBLE FOR THE OUTSTANDING CHARGES.

PATIENT/ AUTHORIZED AGENT'S SIGNATURE: _____