Welcome To Our Office

James W. Bedsole, O.D.

Patient _____ Male _____ Female _____

Address _____ Home Phone # _____

City, State & Zip _____ Work Phone # _____

Date Of Birth _____ Cell Phone # _____

Occupation _____ Employer _____

Primary Care Doctor _____ E-mail Address _____

Referred By _____ Emergency Contact Name _____

Race _____ Home Ph.: _____ Work Ph.:_____

Hispanic _____ Non Hispanic _____

Height _____

Weight _____

Person Responsible for Insurance/Payment _____

Address _____ City, State & Zip _____

Home Phone # _____ Work Phone # _____

Date Of Birth _____ Soc. Sec. # _____

Occupation _____ Employer _____

Insurance _____ I.D. # _____

Statement Of Financial Policy

All fees are due on the same day the services are rendered.

I agree to the terms regarding payment of services and materials. If insurance is filed I assign all benefits to Dr. Bedsole. I understand that I am responsible for charges that insurance does not pay.

Signature _____ Date _____

ACKNOWLEDGEMENT OF PRIVACY POLICY AND PRACTICES

The law requires that Dr. Bedsole make every effort to inform you of your rights related to your personal health information. Dr. Bedsole has established a *Privacy Policy* and guidelines for *Privacy Practices* within the office. This information details the use and/or disclosure of information contained in your personal medical records kept for the purposes of diagnosis, treatment, payment and health care operations. In accordance with HIPAA Regulations, a copy of *Dr. Bedsole's Privacy Policy & Practices* is available to you. Should you choose to have a personal copy, one will be provided to you at no charge.

I understand that:

- My personal information will only be used for insurance purposes and communication with other physicians as necessary for my health care.
- My information will not be sold or used for external marketing purposes.

☐ I have read, understand and acknowledge the *Notice of Privacy Policy & Practices* of Dr. Bedsole and agree to continue my care under said terms.

☐ I have elected not to read the *Privacy Policy & Practices* of Dr. Bedsole.

☐ A copy of the *Policy & Practices* of Dr. Bedsole was given to me today.

I hereby authorize all doctors and employees of Dr. Bedsole's office to share and/or discuss any of my related identifiable health information with the following people:

Name/Relationship _____ Name/Relationship _____

Patient Name (Printed) _____ D/O/B _____ Signature (Guarantor/Relationship) _____ Date _____

Medical History

Name_____Date_____

Date of Birth_____Preferred Pharmacy_____

List any medications you CURRENTLY take (prescription or over-the-counter):

_____

_____

List any allergies to any medications:

_____

_____

List any major surgeries you have had (eyes,heart, etc.):

_____

_____

	YES	NO		YES	NO
Eyes(glaucoma,cataract,retinal diseases, etc)			Cardiovascular (Heart, Cholesterol, Blood Pressure, etc.)		
Loss of Vision, Blur, Glare			Respiratory (Asthma, CPAP, Emphysema, etc)		
Dryness/Excess tearing/ Watering			Gastrointestinal (Stomach, ulcers, Intestinal Disease, ect.		
Redness, Itching, Burning			Genital, Kidney, Bladder (Flomax)		
Foreign body sensations			Muscle, Bones, Joints (Arthritis, R.A., etc)		
Eye pain or soreness			Neurological (Multiple Sclerosis, etc.)		
Crossed Eyes/Lazy Eye			Psychiatric (Anxiety, Depression, Insomnia)		
Sandy/Gritty Feeling			Endocrine (Diabetes, Thyroid)		
Drooping Eyelid			Blood/Lymph (Cholesterolemia, Anemia, Sickle Cell)		
Double vision			Allergic/Immunologic (Hay fever, Lupus, Sarcoid, Sjogrens, etc)		
Pregnant or Nursing			Skin (Skin cancer, melanoma)		

Any other eye related problems:_____

FAMILY HISTORY	YES	NO	RELATIONSHIP TO PATIENT
Macular Degeneration			
Glaucoma			
Diabetes			
Other			

SOCIAL HISTORY

Do you drink alcohol? ____YES ____NO If yes: occasional 1per day 2-3/day 4+/day

Do you smoke? ____YES ____NO If yes: occasional 1per day 2-3/day 4+/day

Signature:_____**Date:**_____