PATIENT INFORMATION SHEET
(PLEASE PRINT)

Doctor: _____
Location: _____
I.D. #: _____
Pref. Location: _____

PATIENT NAME:	☐ Miss ☐ Mrs ☐ Ms ☐ Mr ☐ Dr	_____ *(Last)* *(First)* *(MI)*	_____ *(Date)*
PREFERRED NAME OR NICKNAME (such as "Johnny", "Mrs. Smith" or "Dr. Jones":			
MAILING ADDRESS:	_____ *(Street)* *(City)* *(State)* *(Zip)*		
HOME PHONE: ( )	AGE:	BIRTHDATE:	MALE ☐ FEMALE ☐
CELL PHONE: ( )	SOCIAL SECURITY #:		
E-MAIL ADDRESS:	Yes ❑ No ❑ **Would you like to receive occasional emails from us regarding important eye or practice-related information?**		
EMPLOYER:	WORK PHONE #: ( )		
EMPLOYER ADDRESS:	OCCUPATION:		
SPOUSE'S NAME: ***(If minor, parent's name)***	SPOUSE'S (***or parent***) SS #:	SPOUSE'S (***or parent***) DOB:	

HOW DID YOU HEAR ABOUT THIS OFFICE: (*Please check all those that apply)*

☐ Family Member. If so, who_____ Relationship to you:_____
☐ Friend. If so, who_____
☐ Doctor referral. If so, who?_____ Location? _____
☐ Newspaper ☐ Yellow Pages ☐ Radio ☐ TV ☐ Screening ☐ Self ☐ Billboard ☐ Internet
☐ Other _____

PRIMARY CARE PHYSICIAN & LOCATION:	REGULAR EYE DOCTOR & LOCATION:	
NEAREST RELATIVE or EMERGENCY CONTACT NOT LIVING WITH YOU:	PHONE #: ( )	RELATIONSHIP:
ADDRESS:		
INSURANCE POLICY HOLDER NAME & DATE OF BIRTH (if not the patient). We must have this information to file your claim:		

☐ **I do not authorize Bennett & Bloom Eye Centers to discuss my symptoms, test results and/or treatment with anyone other than myself or my insurance carrier.**

INSURANCE AUTHORIZATION AND AGREEMENT

I hereby authorize Bennett & Bloom Eye Centers to furnish information to insurance carriers concerning my illness and I hereby assign to the doctor all payments for medical services to myself or my dependents.

I understand I am responsible for deductibles, co-pays, non-covered services, coinsurance and items not covered by my insurance company and all fees associated with collection of these amounts.

Signature: _____ Date: _____ By: _____

Our practice is now collecting new demographic data to aid health agencies understand healthcare disparities, improve quality of care, and strengthen research and outreach. We appreciate your assistance in meeting these new national standards. Bennett & Bloom is dedicated to being your partner in improving patient care. In order for our practice to meet new government regulations please answer the following three questions.

WHAT IS YOUR RACE/DESCENT (please check box)

American Indian or Alaskan Native		**White / Caucasian**	
Asian		**Multi-racial**	
Black or African American		**Other:**	
Native Hawaiian or Other Pacific Islander		**Decline to specify**	

WHAT IS YOUR PREFERRED LANGUAGE (please check box)

English		**Unknown**	
Spanish		**Decline to specify**	

WHAT IS YOUR ETHNICITY / HERITAGE / CULTURAL GROUP (please check box)

Hispanic or Latino		**Unknown**	
Non Hispanic or Latino		**Decline to specify**	

Consent for Use or Disclosure of Patient Information for the Purposes of Treatment, Payment and Healthcare Operations

I hereby consent to Bennett & Bloom Eye Centers (the "Practice") using or disclosing my protected health information for providing treatment to me, obtaining payment for health care services rendered to me or to carry out the Practice's health care operations. This includes appointment reminders via email, text message and voice calls via the contact information you provide.

I also consent to the Practice using or disclosing my protected health information for treatment activities provided by another health care provider, as well as the payment activities conducted by another health care provider or entity. This includes appointment reminders via email, text message and voice calls via the contact information you provide. I further consent to the disclosure of my protected health information for another provider or health care entity to conduct health care operations including quality assessment and reviewing the competence of health care professionals. Medical scans and pictures are used to document diseases, follow their progression or regression, and guide treatment decisions. I authorize their use for educational purposes including medical and scientific lectures, publications and teaching collections. All identifying data and protected health information will be removed.

Specific Records Expressly Excluded. I DO NOT authorize release of the following information for the purposes of treatment, payment and health care operations, if it is part of my protected health information (Check any or all you do not agree to authorize for release):

___Chemical Dependency/Substance Abuse ___Drugs ___Alcohol ___Sexually Transmitted Diseases

I further acknowledge the Practice has provided me a copy of its Notice of Privacy Practices, which provides a detailed description of the uses and disclosures allowed by this consent, as well as other rights I have regarding my protected health information.

_____ _____

Signature of Patient or Personal Representative Date

_____

Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority

☐ **I authorize Bennett & Bloom Eye Centers to discuss my symptoms, test results/treatment and/or account information with the following individuals:**

Name	Relationship to Patient	Phone Number

☐ **I do not authorize Bennett & Bloom Eye Centers to discuss my symptoms, test results, treatment and/or account information with anyone other than myself, my insurance company or another health care provider involved in my care.**

***CONSENT TO RECEIVE MESSAGES** –

If at any time I provide a telephone number or email address at which I may be contacted, I consent to receive communications from this practice.

_____ _____

Signature of Patient or Personal Representative Date

Patient Acknowledgement for Dilation, Treatment and FU

Precautions Following Eye Dilation

I understand that my eye(s) might be dilated as part of my examinations or treatments. This will cause my eye(s) to be sensitive to light and to be blurry for at least several hours. This will make it difficult for me to be outside in bright light, to read, or to drive.

I may ask the receptionist at check-out for a free pair of disposable sunglasses if I feel they are needed.

I will have someone else drive following my office visit, or wait in the office until the above effects of the drops have worn off. Failure to follow this advice could result in injury to myself or others.

_____
Patient Signature

_____
Witness Signature

_____
Date

Recommendations for Treatment and Follow-Up Examinations

I understand that it is my responsibility to follow the advice of my doctor(s) at Bennett & Bloom Eye Centers regarding any treatment recommendations. It is also my responsibility to keep any scheduled appointments or surgeries as recommended by my doctor. Failure to do so may lead to permanent eye damage and vision loss.

_____
Patient Signature

_____
Witness Signature

_____
Date