EYE CARE

Patient Details

Patient Number:	10012	**Patient SSN No:**	1556
Insurance Subscribers:	MemberId	**First Name:**	Michael
Last Name:	Smith	**Gender:**	Male
DOB:	1996-11-02	**Home Phone:**	
Work:		**Mobile:**	7845174512
Email:		**Address:**	85/9
City:	Atlanta	**State:**	2
Zip Code:	32003	**How you found our Office:**	
Ins Sub FName:		**Ins Sub LName:**	
Ins Sub DOB:		**Insurance#Groupon# or SelfPay:**	Selfpay
Vission Ins:			

Insurance Authorization:

I authorize and request my insurance company to pay to the eye doctor benifits otherwise payble 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 2024-01-12

HIPAA PRIVACY ACKNOWLEDGEMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICE:

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michael(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.

☐ I hereby acknowledge reciept of the policy.

☐ I hereby REFUSE to acknwledge reciept of the policy.I understand that even though I refuse to sign this **ACKNOWLEDGEMENT**, the provider may still provide treatment to me.

Sigature **Date** 2024-01-12

Patient Medical History

Name of Primary Care Physician: **City**

Last Date of Check Up: **Current Medications:**

Any Allergies to Medication? - **Have You Had Any Surgeries?**

Do you use cigarettes/tobacco,alcohol, or other substances?

GENERAL HEALTH:

S.No	Health Problem	Status
1	Allergies	Yes
2	Arthritis	No
3	Blood/Lymph	No
4	Broncchitis	No
5	Cancer	No
6	Cholesterol/Lymph	No
7	Diabetes	No
8	Digestive	No
9	Ears/Nose,Throat	No
10	Eczema/Rashes	No
11	Endocrine	No
12	Genitourinary	No
13	High-Blood-Pressure	No
14	Integumentary-(skin)	No
15	Kidney	No
16	Musde-Bone	No
17	Neurological	No
18	Psychological	No
19	Respiratory-COPD-Asthma etc.	No
20	Sinus	No
21	Throat-Infections	No
22	Thyroid	No
23	Unusual-Weight-Loss-Gain	Yes
24	Currently-Preganant	Yes

Patient Eye History

Date Of Last Eye Exam:		**Do You Currently Wear Glasses:**	
Do You Currently Wear Contacts	No	**What kind?**	
Solution Used?		**Would You Prefer Clear, Or Colored Contacts?**	
Are You Satiesfied With The Vision , And Comfort Of Your Contact Lenses?		**Do You Use The Computer?**	
Approx.How Many Hours A Day Do You Use The Computer?		**Occupation:**	

OCULAR SYMPTOMS

S.No	Symptom Name	Check
1	Blurry Vision	checked
2	Other Eye Disorder(s)	checked

FAMILY EYE/MEDICAL HISTORY

S.No	Disease	Status	Whom
1	Blindness	Yes	Father
2	Cataracts	Yes	Uncle
3	Corneal-Problems	No	
4	Diabetes	No	
5	Glaucoma	No	
6	Heart-Disease	No	
7	Lazy-Eye	No	
8	Macular Degeneration	Yes	Mother
9	Retinal-Detachment	No	
10	others	Yes	

BROOKWOOD EYE CARE

OFFICE POLICIES

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

1. All contact Lens and Spectacle Gla·sses 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/deposits may be forfeited

2. **Refunds**: Glasses are individually fabricated so we are unable to accept requests for refunds. Therefore, **All Sales are Final.** Merchandise may be returned within 30 days for exchange or store credit.

3. **Patients own frame** We take great care of patients frames. However, in the process of fitting new lenses into a customers old frame, making adjustments or minor repairs, we will not be responsible for breakages during these processes.**Please knoe that these are done at your own risk.**

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

5. Contact Lens prescriptions are **valid for 1 year** per FDA regulations. Evaluations are required annually.

6. All Contact Lens Exams also include a prescription for glasses.

7. All fittings for Contact Lens examinations are to be completed within 60 days to prevent any additional fitting fees.

8. Doctors prescription changes are done one time at no charge within 60 days of initial order date.

9. All frames placed on hold will be returned back to the display case for sale after two 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 lgss than the act1.1al bill for service. I agree to be responsible for the payment of all services rendered on my behalf or my dependants.

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

Signature 

Date 2024-01-12

My eye doctor provided me with a copy of my contact lens precription at the completion of my contact lens fitting.

Patients Signature: