



## EYE CARE

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### Patient Details

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

### 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 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 RECEIPT OF NOTICE OF PRIVACY PRACTICE:**

**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 receipt of the policy.

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



**Signature**

**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	No
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 Satisfied  
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	No	
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 provide excellent customer service. Please take a moment to review our policies.

1. All contact Lens and Spectacle Glasses 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 know 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 less than the actual 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**

A handwritten signature in black ink, featuring a stylized 'S' shape with a long horizontal stroke extending to the right.

**Date**

2024-01-12

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

**Patients Signature:**

A handwritten signature in black ink, featuring a stylized 'S' shape with a long horizontal stroke extending to the right.