## BULLEOU BULLE

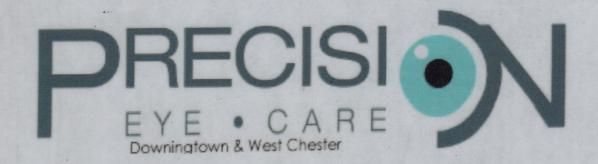
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GENERAL INFORMATION	
First, Last, MI, Preferred Name	
Street Address	
City, State, Zip	
Phone, Type	
Phone 2, Type	
Email	
Preferred Contact Method cell phone   email   text   other (please explain)	
Patient Social Security Number (Last 4)	
Date of Birth	
Male/Female	
Occupation/Employer	full-time   part-time
Marital Status married   single   divorced   legally separated   widowed	
Language, Race, Ethnicity	
Emergency Contact Person and Phone	
INSURANCE INFORMATION	
Vision Insurance	
Vision Insurance Member Name	
Vision Insurance Member ID#	
Vision Insurance Member Date of Birth	
Primary Medical Insurance	
Primary Member Name	
Insurance ID#	
Insurance Policy#/Group ID#	
Primary Member Date of Birth	
Primary Member Social Security Number	
Primary Member Employer	
Your Relationship to Primary Member spouse   child   other (please explain)	
Secondary Medical Insurance	
Secondary Medical Insurance Member Name	
Secondary Medical Insurance ID#	
Secondary Medical Insurance Policy #/Group ID#	
Secondary Medical Insurance Member Date of Birth	
Secondary Medical Insurance Member Social Security Number	
Your Relationship to Secondary Medical Insurance Member	

## STAILS TORM

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EYE HISTORY				MEDICAL HISTORY					
Date of Last Eye Exam			Have you or a family member experienced, or been						
Currently Wear Glasses?			treated for, any of the following? Circle all that apply.						
Currently Wear Contacts?			AIDS/HIV	yes	no	family			
Reason for Today's Visit			Allergies	yes	no	family			
				Arthritis	yes	no	family		
				Asthma	yes	no	family		
				Blood/Lymph Disorder	yes	no	family		
Have you or a family me	mher evner	ioncod o	er boon troated	Cancer	yes	no	family		
Have you or a family member experienced, or been treated for, any of the following? Circle all that apply.			Diabetes	yes	no	family			
Cataracts	yes	no	family	Ears, Nose, Throat Conditions	s yes	no	family		
Crossed Eye	yes	no	family	Gastrointestinal Conditions	yes	no	family		
Glaucoma	yes	no	family	Heart Disease	yes	no	family		
ASIK or RK	yes	no	family	High Blood Pressure	yes	no	family		
_azy Eye	yes	no	family	High Cholesterol	yes	no	family		
Macular Degeneration	yes	no	family	Kidney Disease	yes	no	family		
Retinal Detachment	yes	no	family	Lupus	yes	no	family		
Are you currently experi			erienced,	Neurological Conditions	yes	no	family		
any of the following? Ch				Psychiatric Disorder	yes	no	family		
Blurry Vision	near or d	istance		Seizures	yes	no	family		
Burning				Skin Conditions	yes	no	family		
Discharge				Stroke	yes	no	family		
Double Vision				Thyroid Dysfunction	yes	no	family		
Dryness				Current Medications	700	,,,,	rarmy		
Excess Tearing/Watering	ng			(prescription and over-the	-counter a	nd dosa	ge)		
Eye Infection									
Eye Pain or Soreness									
Floaters or Spots									
Halos				Modication Days Aller					
Headaches				Medication Drug Allergies					
Itching									
Light Flashes				Height	Weight				
Light Sensitivity				Are you pregnant or nursir	ıg?				
Redness				Do you smoke?					
Sandy or Gritty Feeling				Have you ever smoked?					



## CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY AND SIGN AT THE BOTTOM OF THE PAGE.

PURPOSE OF CONSENT: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare options.

NOTICE OF PRIVACY PRACTICES: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notices of Privacy Practices provides a description of our treatment, payment activities, and health information, and of our other important matters about your protected health information. A copy of our Notice accompanies this Consent upon request. We encourage you to read it carefully and completely before signing this Consent. We reserve the right to change our Policy Practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

RIGHT TO REVOKE: You will have the right to revoke this Consent at any time by giving us a written notice or your revocation submitted to the contact person. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:** We will gladly furnish you with a set of our Privacy Notice upon request at any time. The Privacy Notice is also displayed on our lobby wall at all times in plain view of our patients. If at any time you have questions or concerns regarding this law, please feel free to ask us.

ATE:				
ATIENT NAME:	-			
GNATURE:				