Broadway Vision Source

Registration Form

Name _____

Address _____ Today's Date _____

City/State/Zip Code _____ Home Phone _____

Guardian (if applicable) _____ Work Phone _____

Birth Date _____ Cell Phone _____

Employer _____ e-mail address _____

Preferred method to contact you: e-mail___ Text___ Cell Phone___

When was your last eye examination? _____

Previous eye doctor:

_____ _____

Name City/State

If you wear contact lenses, please bring your contact lens prescription in with you. If you do not have the prescription, please indicate the name of the doctor who fit them:

_____ _____

Name City/State

Person to be contacted in case of emergency (local friend or relative)

Name _____

Relationship _____

Phone _____ e-mail address _____

Payment and Insurance Information

Please present your insurance card to our receptionist

- Payment is due in full for professional services on the day of your examination
- Payment of ½ the total cost of any merchandise (eg; glasses, contact lenses) is required when the order is placed. The balance is due in full upon receipt of the merchandise
- We do not provide payment plans (exception: CareCard)
- Bankcards accepted: MasterCard, Visa, American Express For those with health insurance:

Vision insurance may be an *optional* coverage under your health plan (similar to dental coverage). Please verify that you are covered for vision.

Insurance eligibility information that is given to us by your insurance company is not a guarantee of coverage. Any balance is the sole responsibility of the billpayer.

Patient's Primary Health Insurance:_____Group # _____

Subscriber Name:_____Subscriber#_____

Secondary Health Insurance_____Group # _____

Subscriber Name:_____Subscriber #_____

Name of Vision Insurance Company:_____

I authorize Broadway Vision Source or the insurance company to release information required to process my claim. I authorize my insurance benefits to be paid directly to Broadway Vision Source. I accept financial responsibility for all account balances. I understand an annual interest rate of 12%, 1% per month, or a minimum rebilling fee of $2.00 per month will be applied to all patient- responsible balances over 90 days.

Signed (Guarantor)_____Date: _____

24 Hour Cancellation & “No Show” Fee Policy

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Broadway Vision Source therefore reserves the right to charge a fee of $50.00 for all missed appointments (“no shows”) and appointments which are not cancelled with at least 24-hour advance notice.

“No Show” fees will be billed to the patient. This fee is not covered by insurance and must be paid prior to your next appointment. Multiple “no shows” in any 12-month period may result in termination from our practice.

Thank you for your understanding and cooperation as we strive to best serve the needs of all of our patients.

By signing below, you acknowledge that you have received this notice and understand this policy.

_____ _____

Signature Printed Name

Broadway Vision Source

A Member of

Vision Source™

Patient Health History Form

Today's Date:_____

Please complete this form prior to arriving at our office. If you are unable to, please arrive at least 15 minutes prior to your appointment in order to allow time to complete it. This will better assure prompt service. Thank you!

Patient Name:_____ **Birthdate**:_____

Gender: M ☐ F ☐

Race:

___African American
___American Indian or Alaskan Native
___Asian
___Caucasian
___Hispanic
___Native Hawaiian or Other Pacific Islander

Ethnicity:

___Hispanic or Latino
___Not Hispanic or Latino
___Native Hawaiian or Other Pacific Islander

Primary Care Physician:_____

Medical/Family History

Please list all your current medications (including over-the-counter, vitamins, and/or herbal therapy):

_____

_____

_____

List any adverse or allergic reactions to medications or eye drops:_____

_____

List all major surgeries (including eye surgery):_____

_____

Please indicate if any of the condition apply to you or a family member (blood relatives only):

Disease/Condition	Yourself	Family Member	Relationship
Blindness	____	____	_____
Cataract	____	____	_____
Glaucoma	____	____	_____
Macular Degeneration	____	____	_____
Retinal Detachment	____	____	_____
Strabismus (eyes are not aligned with one another)	____	____	_____

Women: Are you pregnant? Yes____ No____
Are you breast feeding? Yes____ No____

Review of Systems: Please indicate below if you have any of the following conditions (with or without medication):

Allergic/Immunologic
____None
____Lupus (SLE)
____Rheumatoid Arthritis
____Environmental Allergies
____Seasonal Allergies
____Other (eg; Latex)

Cardiovascular
____None
____High Blood Pressure
____High Cholesterol
____Heart Disease
____Stroke
____Vascular Disease

Ear, Nose, Throat
____None
____Sinusitis
____Upper Respiratory Infection
____Other

Endocrine
____None
____Diabetes
____Hormone Dysfunction
____Thyroid Dysfunction
____Other

Gastrointestinal
____None
____Acid Reflux/Ulcer
____Colitis
____Crohn's Disease
____Other

General Health
____None
____Cancer
____Fatigue
____Fever
____Trauma
____Weight loss/gain (more than 20 lbs)

Genital/Urinary
____None
____Herpes/Chlamydia
____HIV Positive
____Urinary Tract Infection (existing)
____Other

Hematologic/Lymphatic
____None
____Anemia
____Bleeding Disorder
____Leukemia
____Other

Muscle/Skeletal
____None
____Arthritis
____Ankylosing Spondylitis
____Fibromyalgia
____Other

Neurological
____None
____Epilepsy
____Multiple Sclerosis
____Tremors
____Other

Psychiatric
____None
____Anxiety Reaction
____Bipolar
____Depression
____Schizophrenia
____Other

Respiratory
____None
____Asthma
____Bronchitis
____Emphysema
____Other

Social
____Tobacco Use: (please circle) Current Smoker Packs per day_____ For how long?_____
Former Smoker How long ago did you quit?____
____Recreational Drug(s)
____Alcohol Consumption: Frequency per week/quantity_____

Chief Vision/Ocular Complaint:

	Date of Onset (approximate)	Worsening	Improving
____Annual Exam (no specific complaints)			
____Blurry Vision at Distance	_____	____	____
____Blurry Vision at Near	_____	____	____
____Blurry Vision General	_____	____	____
____Bump/Growth on Lid(s)	_____	____	____
____Double Vision	_____	____	____
____Dry Eye(s)	_____	____	____
____Extreme Light Sensitivity	_____	____	____
____Eye Infection	_____	____	____
____Eye Pain	_____	____	____
____Flashes	_____	____	____
____Floaters	_____	____	____
____Headaches	_____	____	____
____Itchy Eye(s)	_____	____	____
____Loss of Vision	_____	____	____
____Red Eye(s)	_____	____	____
____Other (please elaborate):			

Contact lens wearers: where was your latest prescription obtained (not to be confused with where you obtained your contact lenses)?_____

Please sign below to acknowledge that this form is current:

Signature:_____Date:_____

Acknowledgement of Receipt of Notice of Privacy Practices

My signature below verifies that I have received a copy of the Broadway Vision Source Notice of Privacy Practices.

Name of Patient (print):_____
Signature:_____Date: _____

Signature of Patient Representative (if patient is a minor or an adult unable to sign this form)
_____ Date: _____

Relationship of Patient Representative to Patient:_____