WELCOME TO THE OFFICE OF DR. BOCK O.D. P.C.

We are glad to file your vision and/or medical insurance, but ONLY if all necessary information is provided.

Patient Name _____

Which Form of Contact would you prefer for reminders of upcoming appointments?

Circle One: EMAIL PHONE POSTCARD

Email Address _____

(IF NEW PATIENT): How did you hear about us:

Patient: _____ Other Doctor: _____ Other:_____

INSURANCE INFORMATION:

Medical Insurance _____ ID# or SS#_____

Vision Insurance _____ ID # or SS # _____

Policy Holder's Name _____

First Last Middle

Relationship to Patient _____ (ex: spouse, parent, legal guardian) Employer_____

Address (if different from patient) _____

City _____ State/Zip _____ Date of Birth_____

Secondary Insurance _____ ID # _____

(Fill in only if patient has 2 different insurances)

Policy Holder _____ Relationship_____ Date of Birth_____

I understand that it is my responsibility to provide the correct insurance information regarding my vision and medical coverage. I give permission for Dr. Juliana Bock O.D. P.C. to use my personal information to obtain insurance authorization for treatment of services. I understand authorization **DOES NOT ALWAYS GUARANTEE PAYMENT** and I am responsible for any remaining charges incurred as well as any additional late, legal, or attorney fees associated with collection.

*NOTE: Insurance providers require a copay, if applicable, to be collected **each visit**.

Patient _____ Date _____

Parent/Guardian _____ Relationship _____ Date _____

(if patient under 18)

Juliana Bock O.D., P.C.
Consent for Treatment, Assignment of Benefits, Financial Policies

Patient: _____

- **Consent for Treatment**
  I authorize Dr. Juliana Bock O.D. to provide treatment to myself and my dependent.

- **Assignment of Benefits**
  I request that payment of authorized or applicable private insurance benefits be paid directly to Juliana Bock O.D., P.C. for services provided under her care.

- **Financial Responsibility**
  I understand that Dr. Juliana Bock will file my insurance claim as a courtesy; however, I am ultimately responsible for full payment of all charges. I further understand if my account is referred to a collection agency or attorney I will be responsible for all collection costs including total outstanding indebtedness, accrued interest, late charges and cost of collection. I agree to pay the aforesaid attorney's fees and cost of collection whether or not the attorney files suit.

- **Release of Medical Information**
  I authorized Dr. Juliana Bock O.D. to release necessary medical information to my insurance company, its agents, or any third party payer in order for payable benefits for these services to be determined.

- **Referrals/Authorizations**
  I understand if my insurance company requires a referral, I am responsible for obtaining a referral prior to my visit. If I do not have a referral I will be required to sign a waiver before being seen by the Optometrist and payment in full for services rendered will be collected at check out.

- **Missed Appointments**
  Appointments not cancelled within 24 hours will be billed a $45.00 "no show" fee (existing patient) $75.00 (new patient) We appreciate at least 24 hours notice if you must cancel an appointment.

- **Returned Checks and Credit Card Payments**
  Our office will charge $50.00 for any check that is returned for insufficient funds. Credit card returns are subject to service fees and cancelled orders subject to restocking fees.

- **RX Copies/Records Release**
  Our office will gladly provide you with the original copy of a contact and/or glasses prescription however, additional copies will be billed at $5.00 each. Administrative fees for records release may apply. Please allow up to 48 hours for processing.

I have read the above statements and I understand my responsibilities. A copy of this authorization will be considered as valid as the original.

_____ _____

Signature of patient or responsible party Date

Medical History Questionnaire

Name: _____ Today's Date: _____/_____/_____

Address: _____ Home Phone: _____

City: _____ Zip: _____ Work Phone: _____

Guardian (If Applicable): _____ Cell Phone: _____

Birth Date: _____/_____/_____ Social Security #: _____-_____-_____ Place of Employment: _____

Name of Medical Doctor: _____ Occupation: _____

Dr's Phone #: _____ Last Eye Exam: _____/_____/_____

Race (circle one): White / Black or African American / Asian / Hispanic or Latino Height: _____

Native Hawaiian / American Indian or Alaskan Native / Other / Prefer not to say Weight: _____

Ethnicity(circle one): Hispanic or Latino / Non Hispanic or Latino / Prefer not to say Preferred Language: _____

MEDICAL HISTORY:

Do you have any allergies to medications? ◯ No ◯ Yes If yes, explain: _____

_____

List any medications you take (including oral contraceptives and over-the -counter medications): _____

_____

_____

_____

List all major injuries, surgeries and/or hospitalizations you have had: _____

_____

Circle any of the following that you have had: Crossed Eyes Lazy Eye Drooping Eyelid Prominent Eyes

Glaucoma Retinal Disease Cataracts Eye Infections Major Eye Injury

Are you pregnant and/or nursing? ◯ No ◯ Yes

Do you wear glasses? ◯ No ◯ Yes If yes, how old is your present pair: _____

Do you wear contact lenses? ◯ No ◯ Yes if yes, how old is your present pair: _____

Reason for today's visit: _____

FAMILY HISTORY:

Please note any family history (parents, grandparents, siblings, children, living or deceased) for the following conditions:

DISEASE/CONDITION	NO	YES	?	RELATIONSHIP TO YOU (who & maternal/paternal)
Blindness	◯	◯	◯	_____
Cataract	◯	◯	◯	_____
Crossed Eyes	◯	◯	◯	_____
Glaucoma	◯	◯	◯	_____
Macular Degeneration	◯	◯	◯	_____
Retinal Detachment/Disease	◯	◯	◯	_____
Arthritis	◯	◯	◯	_____
Cancer (list type)	◯	◯	◯	_____
Diabetes	◯	◯	◯	_____
Heart Disease	◯	◯	◯	_____
High Blood Pressure	◯	◯	◯	_____
Kidney Disease	◯	◯	◯	_____
Lupus	◯	◯	◯	_____
Thyroid	◯	◯	◯	_____
Other _____	◯	◯	◯	_____

** Please turn this form over and complete side two **

SOCIAL HISTORY:

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

◯ Yes, I would prefer to discuss my Social History information directly with my doctor.

Do you drive? ◯ No ◯ Yes

If yes, do you have visual difficulty when driving? ◯ No ◯ Yes

If yes, please describe: _____

Do you use tobacco products? ◯ No ◯ Yes If yes, type/amount/how long: _____

Do you drink alcohol? ◯ No ◯ Yes If yes, type/amount/how long: _____

Do you use illegal drugs? ◯ No ◯ Yes If yes, type/amount/how long: _____

Have you ever been exposed to or infected with? ◯ Gonorrhea ◯ Hepatitis ◯ HIV ◯ Syphilis ◯ No

REVIEW OF SYSTEMS:

Do you currently have any problems in the following areas:

SYSTEM	NO	YES	?
CONSTITUTIONAL			
Fever,Weight Loss/Gain	◯	◯	◯
INTEGUMENTARY (Skin)	◯	◯	◯
NEUROLOGICAL			
Headaches	◯	◯	◯
Migraines	◯	◯	◯
Seizures	◯	◯	◯
EYES			
Loss of Vision	◯	◯	◯
Blurred Vision	◯	◯	◯
Distorted Vision/Halos	◯	◯	◯
Double Vision	◯	◯	◯
Dryness	◯	◯	◯
Mucous Discharge	◯	◯	◯
Redness	◯	◯	◯
Sandy/Gritty Feeling	◯	◯	◯
Itching	◯	◯	◯
Burning	◯	◯	◯
Foreign Body Sensation	◯	◯	◯
Excess Tearing/ Watering	◯	◯	◯
Glare/Light Sensitivity	◯	◯	◯
Eye Pain or Soreness	◯	◯	◯
Chronic Infection of Eye/Lid	◯	◯	◯
Sties or Chalazion	◯	◯	◯
Flashes/Floaters in Vision	◯	◯	◯
Tired Eyes	◯	◯	◯
ENDOCRINE			
Thyroid/ Other Glands	◯	◯	◯
Elevated Cholesterol	◯	◯	◯

SYSTEM	NO	YES	?
EARS, NOSE, MOUTH, THROAT			
Allergies/Hay Fever	◯	◯	◯
Sinus Congestion	◯	◯	◯
Post-Nasal Drip	◯	◯	◯
Chronic Cough	◯	◯	◯
Dry Throat/Mouth	◯	◯	◯
RESPIRATORY			
Asthma	◯	◯	◯
Chronic Bronchitis	◯	◯	◯
Emphysema	◯	◯	◯
VASCULAR / CARDIOVASCULAR			
Diabetes	◯	◯	◯
Heart Pain	◯	◯	◯
High Blood Pressure	◯	◯	◯
Vascular Disease	◯	◯	◯
GASTROINTESTINAL			
Diarrhea	◯	◯	◯
Constipation	◯	◯	◯
GENITOURINARY			
Genitals/Kidney/Bladder	◯	◯	◯
BONES / JOINTS / MUSCLES			
Arthritis	◯	◯	◯
Muscle Pain	◯	◯	◯
Joint Pain	◯	◯	◯
LYMPHATIC / HEMATOLOGIC			
Anemia	◯	◯	◯
ALLERGIC / IMMUNOLOGIC	◯	◯	◯
PSYCHIATRIC			
Depression/Anxiety	◯	◯	◯

If you answered YES to any of the above or have a condition not listed, please explain briefly:

_____

_____

_____

_____ _____

DOCTOR'S SIGNATURE Date

Juliana Bock O.D., P.C.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I, _____, have read a copy of the "Notice of Privacy Practices" for Juliana Bock O.D., P.C. (*posted at front desk*). As provided in our Notice, the terms of the Notice may change. If we change our Notice, you may obtain a revised copy.

I understand that I may access my medical records at any time and that I may copy and/or inspect my protected health information (PHI) to be used or disclosed in accordance with Juliana Bock O.D., P.C. policy. I understand that Juliana Bock O.D., P.C. may charge me for copies of such records, or completion of medical record forms, however a fee schedule will be provided for me upon request.

I understand that Juliana Bock O.D., P.C. has the right to deny me access to my records in certain circumstances, in accordance with the law: however, in such instance they will provide me with a denial in writing.

AUTHORIZATION FORM FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. It has been explained to the patient that disclosures may be made to family and friends related to the patient's health. It has also been explained that we will only disclose information relevant to current treatment. **We will only disclose health care information to (list all that apply):**

NAME	PHONE #	RELATIONSHIP
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

By signing this form, I am consenting to allow Juliana Bock O.D., P.C. to use and disclose my protected health information about me to carry out treatment, payment and health care operations. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Juliana Bock O.D., P.C. may decline to provide treatment to me.

_____

Printed Name of Patient

_____ _____

Signature of Patient or Patient's Representative Date

_____ _____

Printed name of Patient's Representative Relationship