BUKOWSKI & SEXTON EYE CARE

New patient form

Legal name_____ Date of birth: _/__/_
Preferred name _____

Street address **City/ State/ Zip code**

Cellphone number: ___-___-_____ Is it okay for us to **call / text** you a reminder?

Email address: _____ Is it okay for us to **email** you a reminder?

Sex Assigned At Birth: M**/** ◯**F** **Pronouns: he/him she/her they/them**

Primary language: _____ Occupation: __
Primary care physician: _____ When was your last physical? __

Height? _____ Weight? _____ Any chance you are pregnant or breastfeeding? / No

*****Please list all current medications (including eye drops & over the counter meds):**

_____

_____

*****Please list any allergies to medications:** **Please list any other allergies/sensitivities:**

_____

Previous eye provider: _____ **When was your last eye exam?**

Do you wear glasses? / Do you wear contact lenses? /

Have you had trauma or surgery to your eyes? / (if so, please list)

_____

Please list any other surgeries:

_____

Do you drink alcohol? **/**
Do you use tobacco products? **/**

Do you use marijuana? **Y / N**
Do you drive? **Y / N**

Please indicate if you are experiencing any of the following symptoms ((check all that apply):

- ❑ Blurry vision
- ❑ Fluctuations in vision
- ❑ Dryness
- ❑ Burning
- ❑ Itching
- ❑ Redness
- ❑ Tearing
- ❑ Eye Strain
- ❑ Eye Pain
- ❑ Discharge
- ❑ Glare
- ❑ Headaches
- ❑ Flashes
- ❑ Floaters
- ❑ Lid swelling
- ❑ Lid drooping
- ❑ Loss of side vision
- ❑ Blacking out of vision

Have you ever been diagnosed with the following (check all that apply):

- ❑ Lazy eye/amblyopia
- ❑ Cataracts
- ❑ Glaucoma
- ❑ Macular Degeneration
- ❑ Retinal Detachment
- ❑ Uveitis/Iritis
- ❑ Eye infection
- ❑ Eye injury/trauma
- ❑ Bell's Palsy
- ❑ High blood pressure
- ❑ Heart disease
- ❑ High cholesterol
- ❑ Stroke
- ❑ Diabetes Type 1
- ❑ Diabetes Type 2
- ❑ Migraines
- ❑ Seizures
- ❑ Thyroid Disease
- ❑ HIV
- ❑ Herpes
- ❑ Anemia
- ❑ Sickle Cell Anemia
- ❑ Lyme Disease
- ❑ Asthma
- ❑ Anxiety
- ❑ Depression
- ❑ Bipolar disorder
- ❑ Autism Spectrum Disorder
- ❑ Hearing loss
- ❑ Seasonal allergies
- ❑ Tuberculosis
- ❑ Sarcoidosis
- ❑ Crohn's Disease
- ❑ Ulcerative Colitis
- ❑ Kidney Disease
- ❑ Arthritis
- ❑ Lupus
- ❑ Sjogren's Syndrome
- ❑ Multiple Sclerosis
- ❑ Rosacea
- ❑ Psoriasis
- ❑ Eczema
- ❑ Neurofibromatosis
- ❑ Cancer- type(s): _____
- ❑ Other mental illness: _____
- ❑ Other autoimmune disease: _____
- ❑ Other: _____

Please indicate if anyone if your immediate family has been diagnosed with the following (check all that apply):

- ❑ Lazy eye/amblyopia
- ❑ Cataracts
- ❑ Glaucoma
- ❑ Macular Degeneration
- ❑ Retinal Detachment
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Diabetes
- ❑ Cancer

OFFICE POLICIES

Late Policy: Patients running more than 15 minutes late may need to be rescheduled.

Cancellation Policy: Cancellation of an appointment less than 24 hours before the appointed time is subject to a $25 fee. Cancellation must be completed via phone call.

No Show Policy: Failure to arrive for a confirmed appointment is subject to a $50 fee.

In compliance with a new FTC rule in effect 09/24/2024, all patients of Bukowski & Sexton Eye Care must sign that they have received an updated copy of their glasses prescription before being offered the sale of glasses.

CONTACT LENS ASSESSMENTS

Here are our updated contact lens assessment fees as of 09/01/2024:

New Sphere fit: $150
New Toric fit: $175
New multifocal fit: $200
No change in Rx renewal: $75
Change in Rx renewal: $95-$150

HIPAA CONSENT FORM

I give Bukowski Eye Care my consent to use or disclose my personal information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality service.

I have been informed that I may review Bukowski Eye Care's Notice of Privacy Practices before signing this consent.

I understand that Bukowski Eye Care has the right to change their Notice of Privacy Practices and that I may obtain any revised notices at the practice.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that Bukowski Eye Care is not required to agree to the request. If Bukowski Eye Care agrees to my personal restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

Signature: _____ Date: _____
Relationship to patient (if parent, guardian, or representative): _____

PERMISSION TO BILL INSURANCE

I give permission to Bukowski Eye Care to file for insurance benefits to pay for the care I receive.

I understand that Bukowski Eye Care will send my medical information to my insurance company.

I understand that I must pay for the cost of the care I receive if my insurance company does not pay or I do not have insurance.

I understand that I have the right to say no to any treatment or procedure, I have the right to discuss all medical treatments with my provider, and I have the right to ask about costs before I am treated.

Signature: _____ Date: ____/____/_____
Relationship to patient (if parent, guardian, or representative): _____

ACKNOWLEDGEMENT FOR REFERRALS/PRIOR-AUTHORIZATIONS

By signing below, I consent to additional specialty medical testing at Bukowski & Sexton Eye Care. I understand that if my insurance requires a referral/prior-authorization for this testing that I am responsible for obtaining it for the date of service, otherwise I am responsible for the charges incurred.

Signature: Date: ____/____/_____
Relationship to patient (if parent, guardian, or representative): _____

CONSENT FOR DILATION

I DO / DO NOT (circle one) give Bukowski Eye Care permission to dilate my eyes.

I understand the importance of dilated eye exams and the risks/side effects have been explained to me.

I have been given the chance to ask any questions I have about the procedure of dilation.

Signature: _____ Date: ____/____/_____
Relationship to patient (if parent, guardian, or representative): _____