Welcome to Bingham Family Vision

Today's Date:_____
Name: First_____Middle Initial _____Last:_____ **M/F**
Address:_____**City**:_____**State**:_____**Zip**_____
Date of Birth:_____**Age**:_____**Email**:_____
Occupation:_____ **Hobbies**:_____
Phone:_____ **Preferred Contact Method: Text/Email/Phone**

Reason for visit today: New Glasses____ New Contacts____ Other_____

PATIENT MEDICAL HISTORY

Have **YOU** ever had or been diagnosed with**:**

Y/N Diabetes
Y/N High Blood Pressure
Y/N Rheumatoid Arthritis
Y/N Allergies
Y/N Heart Disease
Y/N Thyroid
Y/N Multiple Sclerosis
Y/N Recurring Eye Infections
Y/N Eye Injury
Y/N Eye Surgery
Y/N Eye Turn/Lazy eye
Y/N Cataracts
Y/N Glaucoma
Y/N Macular Degeneration

FAMILY History:
Y/N Glaucoma
Y/N Cataracts
Y/N Macular Degeneration
Y/N Retinal Detachment
Y/N Other:_____

Y/N Are you currently pregnant or nursing?
Do you smoke? Y / N Do you use alcohol? Y / N
Y/N Other Medical/Eye conditions:_____
Y/N Allergic to Medication:_____
Y/N Currently Taking Medication:_____
Other Allergies:_____

Contact Lens Wearers: Marlo is an independent platform powered by Alcon. In order to use Marlo we need your consent to allow us to upload your prescription, exam date, and contact information into Marlo to order contact lenses.
Do you consent to Marlo YES_____ NO_____

Revolution PHR is an online portal to access your eye care records
Do you consent to electronic delivery of glasses/contact prescriptions through PHR YES_____ NO_____

Patient (or Guardian) Signature:_____**Date**:_____

Acknowledgement of receipt of Notice of Privacy Practices (HIPAA)*

By signing below, I acknowledge that I have received or reviewed the Notice of Privacy Practices of Bingham Family Vision, which explains legal duties and privacy practices with respect to my protected health information. I understand that I may refuse to sign this acknowledgement.
Patient (or Guardian) Signature:_____**Date**:_____

Vision Insurance Information

Primary's Name:_____**DOB**:_____**Social Security (last 4) or ID#**_____
By signing below, I certify that I understand that regardless of my insurance status, I am responsible for the balance on my account for services rendered. I also certify that the information contained above is correct to the best of my knowledge at the time this form was completed. I also understand that Bingham Family Vision will only use this information to verify my insurance coverage and keep current records.

Patient (or Guardian) Signature:_____**Date**:_____