Welcome to Bradley Eye Associates

HIPPA COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

Your information is kept confidential and we comply with the Health Insurance Portability Act. Inactive records are professionally destroyed after 5 years.

Patient's Name: _____

Date of Birth _____ /_____ /_____ SS#_____-_____-_____

Address _____

City _____ State GA ☐ _____ Zip Code _____

Home Phone _____ Work Phone _____

CELL PHONE _____ Is it ok to text you? Yes ☐

Email _____@_____

Patient's Employer Name _____ Phone Number _____

Patient's relationship to insured: Self ☐ Spouse ☐ Child ☐ Other ☐ _____

If insured is different from the patient fill out below

Insured's Name _____ SS#_____-_____-_____

Insured's Date of Birth _____ /_____ /_____

ASSIGNMENT OF BENEFITS AND/OR AUTHORIZATION FOR TREATMENT

I hereby authorize treatment of the person listed above and further authorize that any payment of benefits be made to the provider of these services on the patient's behalf. If for any reason my insurance refuses to pay the claim, I will be responsible for the full balance. In the event my account must be placed with a collection agency, I will be responsible for any collection and attorney's fees. I will notify Bradley Eye Associates in writing should I wish to revoke this authorization.

**The refraction is a test performed to establish how well a person can see. The results may be used to determine a prescription for glasses. Refractions are a necessary part of the eye exam.* WE REGRET THAT MEDICARE WILL NOT PAY FOR THIS TEST.

I attest that I have received and reviewed the Notice of Privacy Practices under HIPPA, and have attained a copy for my personal records.

I give my permission to Dr. Bradley and staff to release any medical information related to vision services , exam findings, insurance information, chart notes, and any information therein to other doctor(s) being referred to or requesting information and for purposes of filing insurance.

Signature_____ Date _____

RELATIONSHIP TO THE PATIENT: Self Parent Spouse Guardian (Circle one)

Patients Name _____ Date of Birth _____ /_____ /_____

Medical/Ocular/Social History				
	Self		**Family**	
Asthma	Yes ☐	No ☐	Yes ☐	No ☐
COPD	Yes ☐	No ☐	Yes ☐	No ☐
Other breathing difficulties	Yes ☐	No ☐	Yes ☐	No ☐
Heart condition	Yes ☐	No ☐	Yes ☐	No ☐
Diabetes	Yes ☐	No ☐	Yes ☐	No ☐
Arthritis	Yes ☐	No ☐	Yes ☐	No ☐
High Blood Pressure	Yes ☐	No ☐	Yes ☐	No ☐
High Cholesterol	Yes ☐	No ☐	Yes ☐	No ☐
Stroke	Yes ☐	No ☐	Yes ☐	No ☐
Cancer	Yes ☐	No ☐	Yes ☐	No ☐
Leukemia	Yes ☐	No ☐	Yes ☐	No ☐
Thyroid	Yes ☐	No ☐	Yes ☐	No ☐
HIV/Aids	Yes ☐	No ☐	Yes ☐	No ☐
Glaucoma	Yes ☐	No ☐	Yes ☐	No ☐
Macular Degeneration	Yes ☐	No ☐	Yes ☐	No ☐
Cataracts	Yes ☐	No ☐	Yes ☐	No ☐
Do you smoke?	Yes ☐	No ☐		

Any other eye conditions or eye history? _____

Any other medical conditions that we should be aware? _____

Allergies to any medications? No ☐ Yes ☐: Penicillin ☐ Codeine ☐ Sulfa Drugs ☐ Other ☐

_____

_____

List any medications you are currently taking: _____

_____

_____

List persons with whom we may discuss your medical information:

Name _____ Phone _____

Name _____ Phone _____