14701 N Santa Fe
Edmond, OK 73013

Acct_FullName
Acct_Address1 Acct_Address2
Acct_CityStateZip

Welcome to BVA

BVA Advanced Eye Care

Your Appointment Date:_______________

Time:______________________________

Doctor/Location:_____________________

- ✓ Please arrive 10 minutes early to your appointment. Be prepared for up to 3 hours at your appointment.
- ✓ Fill out and bring all forms with you.
- ✓ Have your photo id and insurance cards ready upon arriving to expedite your wait time.
- ✓ Please bring ANY and ALL medication, allergy, and surgery lists you may have to your appointment. Do not bring bottles, only lists if you have them.
- ✓ If you need to reschedule please give us 24 hours notice.
- ✓ Check with our office if you aren't sure if you need to remove your contact lens prior to your appointment
(some appointments require this for a couple of weeks prior to your appointment)
- ✓ You may need a driver.
- ✓ You can call or text us at 405-752-2733 (Edmond)
405-310-3088 (Norman) if you have any questions.

Patient Information as of _______________________ (enter today's date)
(Please Print Legibly & Fill in or Correct All Fields)

Patient Name:____
Last First Middle

Address:____
Street & Apt# City State Zip

Home Phone:__________________________ Cell Phone: ______________________

Can we text you? ☐Yes ☐ No Email: _________________________________

Preferred Method of contact:____

Birthdate:_______________________ SS#:_________________________

Sex: ☐ Male ☐ Female

Marital Status: ☐Married ☐Single ☐Divorced ☐Widowed

Race: ☐American Indian/Alaska Native ☐Asian ☐Black/African American ☐Hispanic

☐Native Hawaiian/Other Pacific Islander ☐White ☐Prefer not to answer

Ethnicity: ☐Hispanic/Latino ☐Not Hispanic/Latino ☐Prefer not to answer

Preferred Language: ☐English ☐Spanish ☐Other:_____________________________________

Patient's Employer:__________________________ Occupation:________________________________

Work Phone:______________________ Is it okay to call you at work? ☐Yes ☐ No

Address:____
Street & Apt# City State Zip

How did you hear about us? ____

Optometrist:___________________________ Referring Physician:_________________________________

Primary Care Physician:____

Reason for today's visit:____

If this is due to an accident, please provide accident date:______________________________________

Insurance/Patient Responsibility

☐Bill Insurance (cards have been provided) ☐Self Pay

Responsible Party (if different from patient**)**

Name:____________________________ Relationship to patient:________________________________

Phone:______________________________

Patient Name: ______________________________
DOB: ______________________________

Medical History	YES	NO		YES	NO
Blindness			Lupus		
Cataracts			Stroke		
Diabetic Retinopathy			Thyroid		
Glaucoma			AIDS/HIV		
Macular Degeneration			Bleeding/Clotting		
Retinal Detachment			Hepatitis (Type________________)		
Arthritis (Type _________)			Sleep Apnea, Asthma, Emphysema		
Cancer, including skin Cancer			Sjorgren's		
Heart Disease			Alzheimer's/Dementia		
High Blood Pressure			Have you ever taken Flomax		
High Cholesterol			Do you have a Defibrillator?		
Kidney Disease			Other:		
Lung Disease			Other:		
Diabetes:			Diagnosed______ Most recent blood sugar reading:________AIC		

FAMILY HISTORY: Does any member of you immediate family have? If so who?			
Blindness		Diabetes	
Cataract		Hypertension	
Glaucoma		Heart Disease	
Macular Degeneration		Stroke	
Cancer		Arthritis	

Past Surgeries, Trauma, Hospitalizations	
	Date:
	Date:
	Date:
	Date:
	Date:

Are you currently Experiencing?	YES	NO	Are you currently Experiencing?	YES	NO
Fever			Weight Loss		
Unusually Tired			Blood Transfusion		
Difficulty Hearing			Sneezing		
Upset stomach			High Blood Pressure/Racing Pulse		
Shortness of Breath			Bleeding/Anemia		
Kidney or Bladder Problems			Joint Pain		
Skin Conditions			Anxiety or Depression		
Diabetes					

Patient Name: ______________________________

DOB: ____________________________________

Are you currently Experiencing?	YES	NO	Are you currently Experiencing?	YES	NO
Loss of Vision			Redness		
Fluctuated Vision			Distorted Vision		
Loss of Side Vision			Double Vision		
Dryness			Mucus		
Burning or Itching			Sandy/Gritty Feeling		
Excess Tearing/Watering			Crossing Eyes		
Eye Pain/Soreness			Drooping Eyelid		
Tired Eyes			Flashes of Light		
Lazy Eye			Floaters		
Blurry Vision					
Social History	**YES**	**NO**		**YES**	**NO**
Are you pregnant?			Do you wear glasses?		
Do you smoke?			Packs per day?_____ of Years?____		
Previous smoker?			Year quit _____Packs per day? ___# of Years? ____		
Do you drink alcohol?			Drinks per week _______		
Do you drive?			Do you have visual difficulty when driving/or problems with night vision?		
Do you wear contacts?			Last worn____ Type________		

Current Medications: (including aspirin, herbs, supplements and EYE drops)		
Med:	Dose:	X per day:
Med:	Dose:	X per day:
Med:	Dose:	X per day:
Med:	Dose:	X per day:

Allergies or sensitivity to medicines			
Drug:	Reaction:	Drug:	Reaction:
Drug:	Reaction:	Drug:	Reaction:
Other Allergies:			

Current Height:____________ Current Weight:___________	
Pharmacy:	Phone Number:

Patient Name: ________________________________

DOB: __________________________________

CONSENT FOR DILATING EYE DROPS WHILE UNDER THE CARE OF BVA DOCTORS

A variety of eye drops may be administered during the course of your eye examination. Dilating drops enlarge the pupils of the eye to allow for the examination of the inside of your eye. These drops usually cause blurred vision. The length of time vision will be blurred and the degree of eyesight impairment varies from person to person. It is not possible for your doctor to predict how much or how long your vision will be affected. Driving even in low light conditions may be difficult or impossible after an examination with dilating drops, and, if possible you should not drive yourself afterwards.

Instead, we strongly suggest you make alternate arrangements for transportation after your examination. If you choose to drive yourself, you acknowledge that you understand the risks and accept full responsibility for any injuries to yourself or others. Also, we strongly suggest you use sunglasses to reduce your increased sensitivity to light while driving. Although uncommon, the potential for adverse reactions from eye drops does exist, such as acute angle-closure glaucoma, which may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

You hereby authorize BVA doctors and/or assistants to administer dilating eye drops or other eye drops during the course of your treatment. You understand that these eye drops are necessary to diagnose your condition. You further understand and acknowledge that you have been warned of the potential risks that dilating eye drops may have on your ability to drive and will take appropriate steps to reduce this risk by not driving immediately after your eyes have been dilated or by wearing sunglasses while driving.

____ _______________________

Patient (or patient's authorized representative) Date

Patient Name: ________________________________
DOB: __________________________________

PATIENT AUTHORIZATION

Assignment of Medicare and Insurance Benefits and Acknowledgement of Privacy Practices

I request that payment of authorized Medicare, Medigap, or any other insurance be made on my behalf to BVA Advanced Eye Care for any service furnished to me by a physician of the group. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services (CMS) , or any other insurers and its agents any information needed to determine these benefits payable for related services. In Medicare assigned cases, or insured contracts, the provider agrees to accept the charge determination of the Medicare carrier or insured contracts, I am responsible for the deductible (Medicare deductible $198.00), co-insurance (or the 20% Medicare) or insurer does not pay, and for any non-covered services.

I understand I am responsible for my bill in the event Medicare or my insurer denies the claim. I authorize release of medical records to my primary care physician or any other physician associated with continuity of my care.

I authorize BVA Advanced Eye Care, its assignees, and third party collection agents to utilize all contact information I have provided to communicate with me. This includes, but its not limited to, home telephone, cellular telephone, and employment telephone. I hereby grant permission and consent to BVA Advanced Eye Care, its assignees, and third party collection agents to place calls to my home telephone, cellular telephone, and employment telephone; leave messages (whether voice or text); and utilize pre-recorded/artificial voice messages and/or automatic dialing devices in connection with any communication to me. Additionally, I understand that some procedures/services performed by the physician(s) may not be covered by my insurance plan. If services are not covered, I understand and agree to be financially responsible for payment for such services.

AUTHORIZATION OF CARE

I authorize BVA to examine me and perform such tests and procedures as are reasonable and necessary in the diagnosis and treatment of my care. If I am not the patient, but instead signing on behalf of the patient, I further certify that I am legally authorized to sign on the patient’s behalf.

Signature:____ Date:___________________________

Representative Signature:_____________________________________ Date:___________________________

Patient Name: ______________________________

DOB: ______________________

PATIENT RECORD OF DISCLOSURE

The HIPPA privacy rule provides individuals with the right to request a restriction on notes and disclosures of their protected health information.

Persons to whom my personal health information may be discussed and/or released:

Name:______________________________Relationship:____________________Phone #:_
____

Name:______________________________Relationship:____________________Phone #:_
____

☐ No one other than myself.

Your signature authorizes BVA Advanced Eye Care to disclose information about you to the person(s) indicated above. If applicable, this may include information relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse.

This release is valid unless revoked, in writing, and signed by you. However, such revocation will not effect disclosures made in regard to any previous authorization.

NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of BVA Advance Eye Care's Notice of Privacy Practices. By signing below I am only giving acknowledgement that I have had the opportunity to review the Notice of Privacy Practices. The HIPAA Privacy Notice can be
accessed on-line at www.bva20 -20.com or in the BVA office.

Patient's Signature ____
Date ____

Representative's Signature ____
Date ____

Relationship of Representative to patient ____________________________