Welcome to Our Office

Jay W. Bosco, O.D. **1480 W. Center Rd., Suite 14 ▪ Essexville ▪ MI ▪ 48732**

Name ________________________ **Birth Date**____________ **Soc. Sec.**________________

☐Male ☐Female ☐Single ☐Married ☐Other **Family Physician's name**: ______________________

How would you prefer to be contacted? ☐Cell ☐Home Phone ☐ E Mail ☐Postal

Home Address ______________________________ City ______________ Zip __________

Telephone: Home_________________ Work _________________ Cell _________________

E-Mail Address __________________________ Hobbies _________________________

Employer _____________________________ Occupation _________________________

Preferred Language ☐ English ☐Spanish ☐ Other ________________

Your Race ☐White ☐Black or African American ☐Asian ☐Hispanic ☐Native Hawaiian or other Pacific Island ☐Native American or Alaska Native
Your Ethnicity ☐Not Hispanic or Latino ☐Hispanic or Latino ☐Native Hawaiian or other Pacific Island

Responsible* Party** (if different***)**:** Name __________________ Birth Date__________Soc.Sec. ____________

Address ________________________________City _______________ Zip __________

Telephone: Home ______________ Cell ____________ Employer ____________________

Ocular and Medical History

Do **YOU** have or have you experienced **any problems** in the following areas?

	NO	YES		NO	YES		NO	YES
Cataract	☐	☐	Allergic/Immunologic	☐	☐	Genitals/Kidneys/Bladder	☐	☐
Crossed Eyes	☐	☐	Anemia	☐	☐	Headaches/Migraines	☐	☐
Glaucoma	☐	☐	Asthma	☐	☐	Heart Condition	☐	☐
Macular Degeneration	☐	☐	Bleeding Problems	☐	☐	High Blood Pressure	☐	☐
Retinal Disease	☐	☐	Cholesterol	☐	☐	Integumentary (skin)	☐	☐
Distorted/ Double Vision	☐	☐	Chronic Cough	☐	☐	Joint Pain / Muscle Pain	☐	☐
Eye Injury	☐	☐	Diabetes	☐	☐	Pregnant	☐	☐
Eye Pain or Soreness	☐	☐	Emphysema	☐	☐	Psychiatric	☐	☐
Loss of Vision	☐	☐	Endocrine (thyroid/disease)	☐	☐	Seizures	☐	☐
Flashes/Floaters in Vision	☐	☐	Gastrointestinal	☐	☐			

ADDITIONAL HEALTH ISSUES / INFORMATION NOT LISTED ABOVE:
____

SURGERIES / HOSPITALIZATIONS / INJURIES:
____

CURRENT MEDICATIONS:
____

ALLERGIES: (to medication):
____

WHEN WAS YOUR LAST EYE EXAMINATION? ______________ WHERE? ____________________

Do any **RELATIVES** have **problems** in the following areas?

	YES	**Who?**		YES	**Who?**		YES	**Who?**
Blindness	☐	__________	Crossed Eyes	☐	__________	Macular Degeneration	☐	__________
Cataract	☐	__________	Glaucoma	☐	__________	Retinal Disease	☐	__________

SOCIAL HISTORY: This portion is kept strictly confidential. However, you may choose to discuss this portion directly with your doctor ☐ I would prefer to discuss my Social History information directly with my doctor.

Do you drive? ☐ **No** ☐ **Yes**

Do you use or have you ever used tobacco products? ☐ **No** ☐**Yes** If yes, are you a current everyday user ☐No- ☐Yes A current occasional user? ☐**No** ☐**Yes** If you are a former tobacco user when did you quit? ______________________

Do you ever drink alcohol? ☐ **No** ☐**Yes** If yes, how often: (Circle one): Socially, 1-2 drinks daily, above average use or alcohol dependent?

Do you use illegal drugs? ☐**No** ☐ **Yes** If yes, type/amount /how long:___________________________________

Have you ever been exposed to an infectious disease? ☐ **No-** ☐**Yes** **If yes**, which ____________________

HOW DID YOU HEAR ABOUT OUR OFFICE? ☐ Previous Pt ☐ Insurance Plan ☐Yellow pages ☐Friend or Doctor (name) ____

Consent to Provide Treatment

● I hereby authorize Jay W. Bosco, O.D. to provide a medical examination, diagnostic procedures and treatments consistent with standard of care.

● I am aware that the practices of medicine is not an exact science and acknowledge that no guarantees have been made to me regarding the results of this care and treatment.

Consent to Bill Insurance

● I hereby authorize Jay W. Bosco, O.D. to release any information acquired in the course of my treatment to my insurance company and/or my employer for the purpose of treatment, payment for services, etc.

● I authorize the payment of such benefits to be issued directly to Jay W. Bosco, O.D., who will accept assignment when applicable.

● I **agree to pay any amounts that are not covered by my insurance company.**

Financial Policy

- The office of Jay W. Bosco, O.D. will bill most vision and medical insurance's as a courtesy to our patients. However, it is the patient's responsibility to determine whether coverage exists. In the event of lack of coverage, ineligibility, or for non-covered items or services, the patient will be fully responsible for any charges. Fees for professional services are due when services are provided. We require a minimum of half down on material good, i.e. eyeglasses, contact lenses, etc., prior to ordering and the balance due upon delivery. A monthly finance charge of $5.00 or 1.5% will be assessed on past due balances. Furthermore, the patient agrees to pay all costs associated with collection, including court costs, Attorney fees, and a 35% debt-processing fee, as well as overdraft fees.

Acknowledgment of Receipt of Notice of Privacy Practices (HIPAA)

- I acknowledge that I have received or have been given access to review this office's Notice of Privacy Practices Policy which complies with HIPAA laws, and that I may take a copy of the Notice of Privacy Practice home if I so choose.
- In addition, I authorize ________________________________to have access to my medical as well as financial information.

I certify that I have read and understand these above Consents to the best of my knowledge: (Treatment, Insurance Billing, Financial policy and HIPAA) and that I am legally competent to sign the below Authorization on behalf of the Patient or myself.

Authorized Signature: ____ Date: __________________