

BUKOWSKI & SEXTON EYE CARE
New Patient Form

Legal name: _____

Date of birth: ____/____/____ Preferred name: _____

Street address _____

City _____ State _____ Zip code _____

Phone number: ____-____-____ Email: _____

Can we call/text you a reminder? Y / N Can we email you a reminder? Y / N

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

Primary language: _____ Occupation: _____

Primary care physician: _____

Date of last physical? _____ Height _____ Weight _____

Any chance you are pregnant or breastfeeding? Yes / No

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

Please list any allergies or sensitivities to medications:

Please list any other allergies/sensitivities:

Previous eye provider: _____ Date of last eye exam _____

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

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

Please list any other surgeries:

Do you drink alcohol? Y / N

Do you use products containing marijuana? Y / N

Do you drive? Y / N

Do you use products containing tobacco? Y / N

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

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

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

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

*Other: _____

Please indicate if any immediate family members have been diagnosed with any of the following

Lazy eye/amblyopia	Mother	Father	Sister	Brother	Child
Cataracts	Mother	Father	Sister	Brother	Child
Glaucoma	Mother	Father	Sister	Brother	Child
Macular Degeneration	Mother	Father	Sister	Brother	Child
Retinal Detachment	Mother	Father	Sister	Brother	Child
High blood pressure	Mother	Father	Sister	Brother	Child
High cholesterol	Mother	Father	Sister	Brother	Child
Diabetes Type 1	Mother	Father	Sister	Brother	Child
Diabetes Type 2	Mother	Father	Sister	Brother	Child
Cancer	Mother	Father	Sister	Brother	Child

HIPAA CONSENT FORM

I give Bukowski & Sexton Eye Care my consent to use or disclose my personal information to carry out my treatment, to obtain payment from insurance companies, and for healthcare operations such as quality service.

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

I understand that Bukowski & Sexton Eye Care has the right to change its 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 on how my protected health information is used. However, I also understand that Bukowski & Sexton Eye Care is not required to agree to the request. If Bukowski & Sexton 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 & Sexton Eye Care to file for insurance benefits to pay for the care I receive.

I understand that Bukowski & Sexton 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, or if I do not have insurance.

I understand that I have the right to say no to any treatment or procedure, the right to discuss all medical treatments with my provider, and 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 give Bukowski & Sexton Eye Care permission to dilate my eyes.

Dilation is the use of drops to widen the pupil, allowing a clear, magnified view of the back of the eye, including the retina, optic nerve, and blood vessels. The drops may cause a brief stinging sensation and temporary light sensitivity, with effects lasting for a few hours.

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

I have been given the opportunity to ask questions I have about the dilation procedure.

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

CONSENT FOR RETINAL PHOTOGRAPHY

☐ I DO ☐ DO NOT give Bukowski & Sexton Eye Care permission to take retinal photographs as a part of my comprehensive eye exam.

A Retinal Photo helps us screen for glaucoma, macular degeneration, neurological issues, congenital malformations, and changes in the retina from high blood pressure, diabetes, high cholesterol, and much more.

I understand that *if there is a medical diagnosis*, this photo will be billed to my medical insurance. Otherwise, the co-pay for this procedure is \$39.

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

OFFICE POLICIES (For Your Records)

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

Change in Rx renewal: \$95-\$150

No change in Rx renewal: \$7