Drs. Jordan & Bondurant

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Please follow us on Instagram and Facebook!
Instagram: drs.jordanandbondurantpllc | Facebook: Drs. Jordan and Bondurant, PLLC

Eye care Registration and History

Date: ________________________

Last Name: ____

First Name: ________________________________ **Middle Initial:** _______

Address: ____

City: ____

State: _____________________________ **Zip:** ______________________

Social Security # _________ /________/__________

Home Phone: (_____)____

Daytime Phone: (_____)_______________________________________

Cell Phone: (_____)____

Email: ____

☐ Opt in to text messages reminders and email reminders

Sex ☐ M ☐ F Age ___________ **DOB** _____ /______/______

☐ Married ☐ Widowed ☐ Single ☐Minor ☐ Divorced

Race ☐ White ☐ African American ☐ Asian ☐ Other_________

Ethnicity ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

Occupation____

Patient Employer/School______________________________

Spouse's Name ______________________________________

Birthdate_________________ **SS#**______________________

Spouse's Employer___________________________________

In Case of an Emergency, Contact

(Specify someone who does not live in your household)

Name ____

Relationship ____

Home Phone (_____) _______________________________

Cell Phone (_____) ________________________________

Medications
List all current prescriptions, over-the-counter prescriptions, eye drops
____
____
____

Medications Allergies
List any allergies you may have and reaction.
____
____
____
☐ No Medication Allergies

INSURANCE

Who is responsible for this account? ___________________________ Relationship to Patient _________________
Subscriber's name ____________________________ Birthdate ____________________ SS# __________________
Insurance Company _______________________ ID # ________________________ Group # __________________
Is patient covered by additional insurance? ☐ Yes ☐ No Relationship to Patient ___________________________
Subscriber's name ____________________________ Birthdate ____________________ SS# __________________
Insurance Company _______________________ ID # ________________________ Group # __________________

Please give ALL vision and medical insurance cards to receptionist.

Eye Health History

Medical Doctor's Name__________________________ Previous Optometrist Name __________________________

Do you wear Glasses ☐Yes ☐No · Do you wear contacts? ☐Yes ☐No Type_____________________

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

	Yourself	Family Members		Yourself	Family Members
AIDS/HIV	☐YES ☐NO	☐YES ☐NO	Hepatitis (Type______)	☐YES ☐NO	☐YES ☐NO
Blindness	☐YES ☐NO	☐YES ☐NO	High Blood Pressure	☐YES ☐NO	☐YES ☐NO
Blurred Vision – Distance	☐YES ☐NO	☐YES ☐NO	Lazy Eye	☐YES ☐NO	☐YES ☐NO
Blurred Vision – Near	☐YES ☐NO	☐YES ☐NO	Migraine Headaches	☐YES ☐NO	☐YES ☐NO
Cataracts	☐YES ☐NO	☐YES ☐NO	Night Vision, Poor	☐YES ☐NO	☐YES ☐NO
Diabetes	☐YES ☐NO	☐YES ☐NO	Poor color Vision	☐YES ☐NO	☐YES ☐NO
Discharge from Eyes	☐YES ☐NO	☐YES ☐NO	Retinal Disease	☐YES ☐NO	☐YES ☐NO
Dizzy Spells	☐YES ☐NO	☐YES ☐NO	Seeing Halos	☐YES ☐NO	☐YES ☐NO
Double Vision	☐YES ☐NO	☐YES ☐NO	Seeing Flashes	☐YES ☐NO	☐YES ☐NO
Dry Eyes	☐YES ☐NO	☐YES ☐NO	Shingles	☐YES ☐NO	☐YES ☐NO
Epilepsy	☐YES ☐NO	☐YES ☐NO	Temporary Loss of Vision	☐YES ☐NO	☐YES ☐NO
Eye Surgery	☐YES ☐NO	☐YES ☐NO	Turned Eye	☐YES ☐NO	☐YES ☐NO
Floaters or Spots	☐YES ☐NO	☐YES ☐NO	Twitching Eyelid	☐YES ☐NO	☐YES ☐NO
Glaucoma	☐YES ☐NO	☐YES ☐NO	Watering Eyes	☐YES ☐NO	☐YES ☐NO
Light Sensitive	☐YES ☐NO	☐YES ☐NO			

Are you pregnant ☐YES ☐NO
Blood Transfusion ☐YES ☐NO ☐HIV Positive
Tobacco use: ☐Heavy tobacco smoker ☐Light tobacco smoker ☐Former Smoker ☐Never a smoker
Alcohol Use: ☐Social use only ☐1-2 drinks daily ☐Alcohol dependency ☐Non-Drinker

LIST ALL IMMEDIATE FAMILY MEMBERS THAT ARE PATIENTS OF DRS. JORDAN & BONDURANT, PLLC.
____
____
____

ACKNOWLEDGEMENT OF PRIVACY POLICY & PRACTICES

I understand that in an attempt to protect the privacy of my identifiable health information, Drs. Jordan and Bondurant, has established a Privacy Policy and guidelines for Privacy Practices within their office. This information details the use and/or disclosure of information contained in my personal medical/optometric records kept for the purposes of diagnosis, treatment, payment, and health care operations. In accordance with HIPPA Regulations, a copy of the Privacy Policy & Practices of Drs. Jordan and Bondurant's Office has been made available to me while in the office today. Should I choose to have a personal copy, one will be given to me at no charge.

[ ] I read, understood, and acknowledged the Privacy Policy & Practices of Drs. Jordan and Bondurant.
[ ] I elected NOT to read the Privacy Policy & Practices of Drs. Jordan and Bondurant.
[ ] A copy of Drs. Jordan and Bondurant's Privacy Policy & Practices was given to me today.

____

SIGNATURE TODAY'S DATE

INSURANCE AUTHORIZATIONS · SIGNATURE ON FILE

FOR MEDICARE PATIENTS

I request payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Jordan or Dr. Bondurant for any covered services furnished to me. I authorize any holder of medical information about me to be release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

I understand Medicare will not cover any services determined as routine/screening. I understand I will be financially responsible for these changes. These services include refraction, routine eye exams and low vision aids, exams, glasses, and contact lens (with the exception of after cataract surgery), non-medically necessary tints, scratch coats, other additional patient options for glasses, contact lens cleaners and solutions.

Medicare/Medigap Benefits

I request that payment of authorized Medigap benefits be made either to me or on my behalf to Dr. Jordan or Dr. Bondurant for any services furnished to me. I authorize any holder to medical information about me to release to ________________ (name of medigap insurer) any information needed to determine these benefits payable for related services.

Signed: ____ Date: ____________________

Patient or Guarantor

NON-MEDICARE PATIENTS/ACCEPT ASSIGNMENT

I authorize the release of all medical information necessary to process this claim and that is pertinent to my medical care. I assign all medical and/or post-op surgical benefits including major medical benefits to which I am entitles to Dr. Jordan or Dr. Bondurant. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand I will be financially responsible for the non-covered services and charges.

Signed: ____ Date: ____________________

Patient or Guarantor

Contact Fit Fee/Evaluation

The contact lens evaluation is not so much to check the “strength” of you contact lens but to evaluate the changes the eye has undergone over the past year due to the wear of contact lens. Contact lenses do not naturally belong in the eye but due to advancements in the scientific world this is now possible in a healthy way with proper care and frequent checkups.

Wearing contacts alters the dynamic of the eye. I am monitoring how you eye is doing, just like we monitor any patient taking medication. This type of evaluation is never considered part of an eye examination. The fit fee/evaluation gives you up to 3 follow up visits directly related to contact lens wear and fit within a 90 day period. Please sign a release for the contact fitting/evaluation. This is a requirement to get a contact lens prescription.

____

SIGNATURE TODAY’S DATE

It is our office policy to collect all payments for services rendered and products ordered.